ChapinHall at the University of Chicago
Policy research that benefits children, families, and their communities

Supporting Low-Income Parents of Young Children: The Palm Beach County Family Study 2009

Julie Spielberger
Lauren Rich
Marcia Gouvêa
Carolyn Winje
Molly Scannell
Allen Harden
Kristin Berg

2009

Recommended Citation

Spielberger, J., Rich, L., Gouvêa, M., Winje, C., Scannell, M., Harden, A., & Berg, K. (2009). *Supporting Low-Income Parents of Young Children: The Palm Beach County Family Study 2009.* Chicago: Chapin Hall at the University of Chicago

ISSN: 1097-3125

Chapin Hall
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637

773-753-5900 (phone)
773-753-5940 (fax)

www.chapinhall.org

Supporting Low-Income Parents of Young Children:
The Palm Beach County Family Study 2009

Julie Spielberger
Lauren Rich
Marcia Gouvêa
Carolyn Winje
Molly Scannell
Allen Harden
Kristin Berg

2009

ACKNOWLEDGMENTS

This third report of the Palm Beach County Longitudinal Study would not have been possible without the participation of a large number of people in Palm Beach County. We acknowledge Tana Ebole, Nate Nichols, Grace Watson, Jeff Goodman, Laura Fleischman, Anna Reardon, Tanya Palmer, Sarah Gosney, Scott Davey, and Carol Scott of the Children's Services Council; Denise Pagan of the Florida Department of Health; and Fran Smith and Mark Holsapfel of the Florida Department of Children and Families (DCF), who helped in various ways to clarify the goals and activities of the service system in Palm Beach County, review our methodology and data collection instruments, and obtain administrative data.

In addition to assisting us with our sample development and shepherding the interview process through some difficult periods, the staff of Westat—Crystal MacAllum, Gail Thomas, and their field staff—have been an invaluable source of information and guidance every step of the way as we developed our interview and consent protocols for the study. They also contributed information that assisted us in our analysis and interpretation of findings.

We also thank the following Chapin Hall staff for their contributions: LaShaun Brooks, for help in developing the qualitative study protocols and training and supervising field staff; Elizabeth Dick, Emily Hogue, Srijana Nepal, Diana Sinesterra, and Colleen Supanich, for data collection for the qualitative study; and Rosemary Gill, for help in organizing data collection materials and in preparing this report. In addition, we appreciate the support and guidance we have received from the following Chapin Hall staff: Deborah Daro, Robert Goerge, Harold Richman, John Schuerman, Ada Skyles, and Matthew Stagner.

It goes without saying that we are greatly indebted to the families who are participating in this study. Although, for reasons of confidentiality, we cannot thank them by name, they have opened their doors to us, given us a glimpse into their lives and parenting practices, and shared their goals and hopes for their children and themselves. We have learned and are continuing to learn an enormous amount from them.

Last, we are grateful to the Children's Services Council of Palm Beach County for its commitment to learning from research about their community and how to serve it better as well as its generous support of this study.

TABLE OF CONTENTS

TABLES AND FIGURES

Appendix Tables and Figures

EXECUTIVE SUMMARY

Introduction

During the last 3 decades, considerable progress has been made in understanding the ecological and cultural context for children's development and, in particular, the harmful effects of poverty and its correlates on family functioning and child development (e.g., Bronfenbrenner, 1979, 1986; Brooks-Gunn 2003; Gomby 2005; National Research Council and Institute of Medicine, 2000; Olds, Kitzman, Hanks, et al. 2007; Weisner, 2002). At the same time, a variety of early intervention strategies have been designed to diminish the effects of poverty on children's development and readiness for school. Increasingly, comprehensive, integrated systems of health, educational, and social services have been viewed as a promising strategy for supporting healthy family functioning and child development in low-income, at risk families (Brooks-Gunn 2003; Gomby 2005; Olds, et al. 2007; Reynolds, Ou, & Topitzes 2004).

This growing body of evidence prompted the Children's Services Council (CSC) of Palm Beach County (FL) to undertake a long-term initiative to build an integrated system of care to promote and support the healthy development of children, with a focus on the first 5 years of life. The primary goals for the Palm Beach County system of care are to increase the number of healthy births, to reduce the incidence of child abuse and neglect, and to increase school readiness, as indicated by the number of children who enter kindergarten ready to learn.[1] To pursue this aim, CSC and other stakeholders have developed a set of prevention and early intervention programs and systems serving families and their young children in targeted low-income communities called the TGAs.[2] The primary programs and systems designed to support children at different stages of their development are presented below.

Overview of CSC Programs and Systems

Program/System Name	Program Description
Healthy Beginnings	A network of health and social services for high-risk pregnant women and mothers, which includes universal risk screening before and after birth; targeted assessment and home visitation; and coordinated services for families experiencing medical, psychological, social, and environmental risks that negatively impact pregnancy and birth outcomes
Early Care and Education	Several initiatives intended to identify and provide services for children with developmental delays and improve children's school readiness, and a quality improvement system for childcare programs
School Behavioral Health Programs	Designed to improve children's adjustment to school and enhance their school success by identifying social-emotional and other developmental problems and providing referrals and interventions to respond to these problems.
Afterschool Programs	A network of afterschool programs for elementary and middle-school youth supported by Prime Time, an intermediary working to improve the quality of school-based and community programs

[1] "Palm Beach County's Pathway to Early Childhood Development," CSC draft planning document, August 2007.

[2] At the time of this report, there are four designated TGAs or targeted geographic communities in Palm Beach County. According to the 2003 *State of the Child in Palm Beach County*, 75 to 93 percent of children in the TGAs receive free or reduced lunch; the rate of child abuse and neglect is between 4.1 and 6.6 times the county average; and crime rates in the TGAs range from 14 to 93 percent above the county rate.

A central concern for CSC and other stakeholders in the county is the effectiveness of this emerging system. Is the service system functioning and being used by families as expected? Is it achieving its intended outcomes? Separate evaluations have been conducted on several individual programs and networks that are part of the system (e.g., Spielberger, Haywood, Schuerman, Richman, & Michels, 2005; Lyons, Karlstrom, & Haywood, 2007). Yet, these evaluations alone cannot provide information on how families use the *system* of services or the effects of multiple services on children's well-being and development.

Thus, CSC funded Chapin Hall at the University of Chicago to conduct an 8-year longitudinal study to examine the use and effectiveness of an array of services in the county in promoting school readiness and school success and improving family functioning among children and families most in need of support. The goal of the study is to describe the characteristics and needs of families the service system is intended to serve, how they use the services that make up the service system in Palm Beach County, and how service use is related to indicators of child well-being and family functioning, and child and family outcomes. It began in 2004 and addresses questions in the following areas:

- What services and supports are available and how are they used by families of young children in the TGAs? Are there patterns of service use?
- What are the correlates of service use, including demographic and other family characteristics, indicators of risk and service need, geographic location, nativity, and prior service use?
- How does service use relate to child and family outcomes, including children's school readiness, school success, and physical, social-emotional, and behavioral health; and to family functioning, rates of abuse and neglect, and parent involvement in schools?
- Does the availability of a more complete array of services change the way services are provided to families or makes individual programs more effective? Do families experience larger effects from using an array of services than using individual services?

To address these questions, we are using mixed methods to gather a wide variety of information about the characteristics and needs of families the system is intended to serve, and how families use available services. These methods include analysis of administrative data on service use and key outcomes for all families with children born in the TGAs and in the county during 2004 and 2005 over an 8-year period; annual in-person and telephone interviews with a sample of 531 mothers who gave birth to a child (referred to here as the "focal child") in the TGAs during 2004 and 2005 for 5 years; and a 3-year embedded qualitative study involving in-depth interviews and observations of forty of these families.

Mothers were recruited through two maternal child health programs that are part of the Healthy Beginnings system. To ensure a sufficient sample of mothers who were likely to use services, we over sampled mothers screened at risk around the birth of their child. Of the 531 mothers who participated in the baseline interviews soon after the birth of the focal child, 444 were interviewed in year2, and 399 in the third year; 390 mothers were interviewed all 3 years. This executive summary reports key findings from the third year of the study—when the focal

child was between 24 and 30 months of age—and discusses their implications for the Palm Beach County service system.

Findings

Family and Household Characteristics

- Compared to the population of families with children born in the TGAs and the county during 2004 and 2005, the study sample has more characteristics associated with risks for poor outcomes. A majority (59%) has less than a high school education versus a third (35%) of the TGA birth cohort. Almost three-fourths (72%) was unmarried at the baseline interview versus 57 percent of the TGA cohort. More than half (54%) of the families in the year 3 sample had incomes at or below the federal poverty threshold the previous year. In addition, compared to the TGA cohort, higher percentages of mothers in the sample were Black (38%) and Hispanic (55%); more than half (57%) were foreign-born.
- Household sizes remained fairly constant during the first 3 years of the study. The percentage of mothers who were married in year 3 was the same as in year 2 (30%), although the percentage of unmarried mothers living with a partner (33%) continued to decline from the first (40%) and second (37%) years. Two-thirds of the sample had two or more children at the time of the third interview. Almost one-quarter (24%) of the mothers had given birth to another child since the birth of the focal child, and 8 percent were pregnant at the time of the year 3 interview.
- Although there were only modest changes in family income, educational levels, and marital status over the first 3 years there was a notable increase in the proportion of mothers working part-time or full-time. Whereas only 13 percent were employed at the baseline interview, 45 percent were working at year 2 and 49 percent at year 3.

Maternal Functioning, Parenting Practices, and Child Development

- Most of the study mothers (85%) described themselves as being in "good" to "excellent" physical health in year 3. Fewer mothers expressed clinical symptoms of depression (19%) or parenting stress (11%) on standardized measures than in previous years.
- More than three-quarters of the mothers reported engaging in positive parenting activities, such as praising their child, singing songs, reading books, and taking their child outside to play. For families in which husbands or partners had contact with their children, mothers reported that at least two-thirds of fathers also engaged in most positive parenting activities.
- Smaller percentages of mothers reported using negative parenting practices, such as losing their temper with their child (53%), hitting or spanking their child (31%), and getting angrier with their child than they intended (22%). Mothers reported somewhat lower percentages of negative parenting practices for their husbands or partners than they reported for themselves.
- Most mothers reported the focal children to be in "good" to "excellent" physical health, although 18 percent had asthma or other "special needs" at year 3. Based on mothers' assessments, most children were developing within ranges comparable to the national birth

cohort in the Early Childhood Longitudinal Study (ECLS-B) of children's physical, cognitive, social, and language development (Andreassen & Fletcher, 2007; NCES, 2003).

Childcare Arrangements

- At year 3, more than half (53%) of the mothers were using nonparental care for the focal child, motivated largely by their need for childcare as they returned to work. The most frequently reported type of nonparental arrangement was center care, followed by relative care, and care by a friend or neighbor.
- Although mothers who were employed or in school were significantly more likely to use childcare than mothers who were not, mothers' race/ethnicity and immigrant status also affected childcare use. Mothers who identified themselves as Black—both foreign-born and U.S.-born mothers—were much more likely to use childcare than foreign-born Hispanics.
- Several factors influenced mothers' choice of childcare arrangements including cost, availability, location, and access to transportation. They also were influenced by their beliefs and values about who should care for their children, the quality of care they desired, and their children's development. With children's increasing independence and verbal skills and the greater availability of center-based programs for 3- and 4-year-olds, mothers expressed more interest in childcare that would benefit their children socially and educationally than in previous years.

Social Support

- Mothers with husbands or partners continued to receive a majority of their support from them, although reported levels of support were lower in year 3 than in year 2. Otherwise, mothers relied on other family members, especially siblings and mothers or stepmothers. Friends were an additional source of support, but for less than half of the sample.
- The overall level of reported community support rose between year 2 and year 3, suggesting more interaction with community members than in previous years. More than half of the mothers reported receiving support in the form of advice on children or household problems or help with money, food or clothing from someone in the community. In particular, more mothers cited doctors and teachers as a source of support in year 3 than in year 2.

Service Use, Patterns, and Trends

Healthy Beginnings Services

- Among mothers in the 2004-2005 TGA birth cohort, fewer than half (40%) received services from Healthy Beginnings. Consistent with the population targeted by the Healthy Beginnings system, mothers who were teens, were unmarried, had less than a high school education, were Hispanic, or were foreign-born were more likely to receive services.
- Compared to the TGA cohort, twice as many mothers in the year 3 study sample (80%) used Healthy Beginnings services. Most services were provided during the 3 months before and 6 months after the birth of a child. Only about a quarter of the sample continued to receive services 6 months after the birth of the focal child.

Other Services

- A majority of the study families received help with health care and food assistance during the first 3 years of the study. Across the 3 years, about the same proportion of mothers—20 to 25 percent—received help with dental care, and about a third received help with family planning in years 2 and 3. Compared with year 1, there was a small increase in the proportion of mothers getting help with childcare in year 3.
- All of the focal children received regular medical care and 79 percent were covered by health insurance in the year 3. However, almost a third of all children in the study families (and 21 percent of the focal children) were not covered is a concern.
- An additional concern was that only 39 percent of mothers reported having health insurance for themselves, although a majority (73%) reported receiving regular medical care at the time of the year 3 interview. Native-born mothers were both more likely to receive regular care (82%) than foreign-born mothers (66%) and more likely to have health insurance in the third year (71% versus 15%).
- Even though a majority of mothers received food assistance in year 3, there was a significant decline in assistance years 1 and 2. Qualitative data suggested that, in some cases, changes in employment or family composition affected eligibility for food assistance. Other reasons were mothers' perceptions of their needs, alternative sources of help, assessments of the benefits of assistance versus the application costs of time, transportation expenses, and obligation to share personal information, and missed deadlines for recertification of benefits.
- The proportion of mothers who received help with parenting information also declined significantly between year 1 and year 3. One reason for the decline appeared to be that although still sought this support, they increasingly turned to other sources, including books, magazines, pediatricians, and teachers for parenting information.
- In general, mothers with greater needs received more help, and that mothers whose circumstances changed for the worse also received more help. Results also suggested that, all else being equal, foreign-born mothers—both Black and Hispanic—were less likely to receive help.

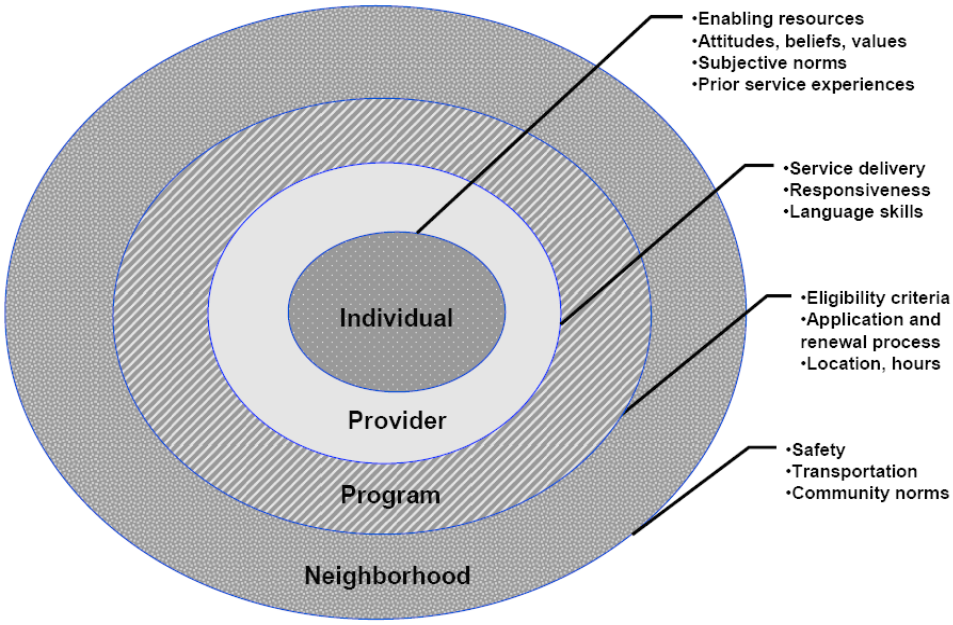
Barriers and Facilitators of Service Use

- Qualitative data suggested that service use was influenced by many factors at different but interconnected levels—the individual, the provider, the program, and the neighborhood level. As shown on the next page, at the individual level, we identified factors such as personal enabling resources (e.g., immigration status, concrete resources, knowledge of services, personal social networks), perception of need, attitudes and beliefs about services, subjective norms (e.g., family approval or disapproval), and previous service experiences.
- Barriers and facilitators to service use among the study mothers began at the individual level and were often related to their personal resources (e.g., language, income). In addition, what posed a barrier to one mother—for example, having to use the computer to apply for a service—would, in fact, be a facilitator for another mother.
- Mothers' commitment to their role as parents and to ensuring their children's well-being was a primary motivation to use services. Although mothers described personal goals (e.g., to go

back to school, get a better job, learn a new language, and achieve financial stability) and said they preferred to be independent and not rely on formal services, they faced innumerable obstacles to achieving their goals. Yet many mothers were willing to make the personal effort needed to address the individual-level barriers, such as transportation, language, and conflicting information about service requirements, to use available services if it meant improving the welfare of their children.

- At the provider level, characteristics of providers such as staff responsiveness, language skills, and cultural competency affect service use. At the program level, factors include eligibility requirements, program structure, availability of translation services, location of services, intake procedures, and the waiting time to apply for or receive services. And at the neighborhood level, factors such as neighborhood safety and community transportation systems affect families' access to and decisions to use services.[3]

Conceptual Model of Barriers and Facilitators of Service Use



- Foreign-born mothers were less likely to seek help from formal service providers than native-born mothers but also encountered more challenges in getting help they sought.
- Social workers and case managers played an important role in connecting study families to needed services that they might not be able to access on their own. Although these providers often were a direct source of parent education and mental health services, among others, they also were an essential bridge to basic services, including Medicaid, food assistance, and childcare subsidies.

[3] We also recognize that the broader social, economic, and political context—for example, national and state immigration policies, the availability of affordable housing, jobs, and transportation systems, and the costs of energy and food—also impacts family circumstances, needs, and access to services.

Outcomes at Year 3

- We found a small, positive relationship between the number of services mothers used in year 3 and their use of positive parenting practices; we also found a small, positive relationship between a mother's use of services and her child's language development. Thus, providing support services to mothers of young children might lead to improved parenting skills and, ultimately, enhanced child development. On the other hand, we also found a small, negative relationship between service use and the number of developmental milestones reached by the focal child, so it will be important to continue to examine the relationship between service use and child outcomes.
- There were some notable relationships between mothers' ethnic characteristics and selected maternal outcomes. First, Black foreign-born mothers were almost 14 times more likely to have depressive symptoms than Hispanic foreign-born mothers; however, we did not find significant differences in the odds of depressive symptoms between U.S.-born Blacks and foreign-born Hispanics, or between U.S.-born and foreign-born Hispanics. Mothers who gave birth as teenagers and mothers who reported more problems with housing were at higher risk of experiencing depression. Second, Black foreign-born mothers also had over 5½ times the odds for a Hispanic foreign-born mother of experiencing parenting stress. In addition to race and nativity, we also found that having more children, and having a child with special needs, increased the odds of experiencing parental stress.

Conclusions and Recommendations

Given that the demographic characteristics of families living in the TGAs are the ones associated with children's poor outcomes for school readiness and achievement, CSC's strategy of targeting its services to families in the TGAs appears to be a sound one for reaching children who are most at risk of not succeeding in school. However, study findings to date suggest that some services might not be reaching many of the TGA families who could benefit from them. Although a large percentage of the study families used available food and health care services in the early years of their children's lives, the percentages using other services were much smaller.

For example, a large majority (80%) of the year 3 sample had contact with the Healthy Beginnings system around the birth of the focal child, but only about a quarter were still receiving services 6 months after birth. In addition, although half of the mothers in the sample used some form of childcare arrangement, only about a third were using either center-based programs or family childcare that might be touched by CSC's early education and childcare quality initiatives or the Comprehensive Services program's screening and referral services. Although families' use of center care probably will increase as their children get older, differences are likely to persist because of the lack of affordable quality childcare and childcare subsidies as well as the individual preferences of families for different types of care.

Just a small proportion (15%) of the study families received services in five areas or more in the third year. Their high service use was associated with being native-born, being Black, having more children, and having a child with special medical needs. They were also more likely to have received services through the Healthy Beginnings system. This means that they had contact with a care coordinator, nurse, social worker, or another professional for a longer

period of time, which likely facilitated their participation in services. Families in our sample with greater needs were more likely to use services, but we also found that immigrant families were less likely to receive services than native-born families.

Thus, as described below, our findings to date suggest both opportunities and challenges in CSC's effort to improve access to and participation in the service system.

1. Keeping families involved in services over time

In this study, more mothers decreased than increased their service use. We saw declines in use of food assistance and formal parenting information. In the case of parenting information, the decline might reflect less perceived need for these services or more pressing concerns, such as food and health care. But it also might reflect the lack of connections to family support and educational services for parents once they leave the Healthy Beginnings system. For example, less than 20 percent of mothers still received intensive care coordination services—services that could connect them to additional parenting resources—after the focal child's first birthday.[4]

In the case of food assistance, fluctuations in employment or family composition might have affected some families' eligibility for food assistance. However, qualitative data suggest a number of other factors that prevented families in need from receiving help with food, including the application costs of time, transportation expenses, and obligation to share personal information, and missed deadlines for recertification of benefits. In this regard, social workers appeared to play an important role in linking mothers to needed services. Expanding case management services for mothers who, while not necessarily "at risk," need help in maintaining their services might be a service that CSC could continue to fund after the initial postnatal period to maintain connections to needed services.

In addition, the responsiveness of service providers was another factor in service use. This indicates the importance of CSC's investments in training for service providers in culturally appropriate and family-strengths-based approaches. Families can be intimidated by program concepts and requirements, and staff who are trained to help families through application processes can reduce future duplication of paperwork as well as client and staff frustration. Over time, investing in changing staff behaviors to better serve disfranchised families with young children might boost families' self-respect, make them feel more positive about seeking and accepting help, and prove cost-effective in reducing their future service needs.

2. Making location and timing of services convenient for families

Of the many factors that constrain service use, the locations of program offices, their hours, and waiting times are often inconvenient for families, especially if they have transportation or childcare problems. Strategies that CSC-funded programs use, such as home visits and traveling service vans, are good alternatives to office visits, especially if they are available during evening and weekend hours. Basing services at schools, Beacon Centers, or childcare centers is another option for reaching families who have children enrolled in school or formal childcare. Efforts to persuade health care providers, schools, and service agencies to provide services at times that are

[4] Although mothers might have been referred to additional services within or outside the system, it also is not clear from available data whether they are connected to these services.

convenient for families, as well as working with employers to allow families time off for appointments with teachers, doctors, or service agencies without jeopardizing their wages, might also increase families' access to services. Raising public awareness of the literacy and educational needs, as well as the service needs, of families might reinforce these efforts.

3. Providing continuity of services during periods of instability

Economic support and childcare subsidy programs with strict income thresholds or work requirements can be problematic for low-income working parents, whose sources of income are irregular. Programs and policies that recognize the changing circumstances of low-income families and try to add to the stability of their lives are more likely to impact a larger number of families. One example is CSC's Continue-to-Care Initiative, which provides transitional support when changes in mothers' education or employment status jeopardize their eligibility for childcare subsidies and lead to disruptions of children's care arrangements. Similar programs in the areas of health care and food assistance might also benefit families.

4. Improving channels of communication for service information

There may be other vehicles (e.g., radio, television, faith-based organizations, and public libraries) for disseminating information to families with limited education or literacy skills, families who do not receive information through family or friends, and families who are not already using other services. The local offices of federal benefit programs are also channels for disseminating information about CSC-funded programs; for example, one of the study mothers was referred by a nurse in the WIC office to a provider in the Healthy Beginnings system.

5. Strengthening relationships with community organizations and other services

CSC's strategies to enhance children's school readiness by improving the quality of childcare and providing referrals through the Comprehensive Services program could benefit families who use formal childcare services, but will not reach the many mothers who are not working, who are either not eligible or on a waiting list for a childcare subsidy, or who prefer to use other childcare settings. Other strategies are needed to reach these families, for example, through community outreach and other service providers. Family empowerment programs also can be an effective source of information about services, support, and advocacy and might be most effective when they partner with the programs most families already use, such as WIC, public health clinics, and Medicaid.

Most mothers in the study sample told us that they get what they perceive as an adequate level of support from family members, but there is also evidence that these informal support networks can be fragile and may not always add stability to their lives. On the other hand, there was an increase in reported levels of community support, especially by medical personnel, in the third year. Strengthening connections with pediatricians and nurses and informing them about available parenting services might be another way to increase families' awareness and knowledge of these services.

6. Engaging harder-to-reach families

Some segments of CSC's target population appear harder to reach and engage in services than others. Immigrant families, especially those with undocumented members, pose a particular

challenge. Although the adults in these families might be ineligible for some programs, their children who are U.S. citizens are eligible for services such as food stamps, health insurance, and health care. More effort could be given to informing these families of their children's rights to services and the potential benefits to their children of using them and helping families with the language, literacy, technical, or other knowledge needed to navigate the application process is also needed. Besides reaching these families through the services they do use, this implies partnering with agencies that work specifically with immigrant populations and identifying other resources in immigrant communities through which to reach these families. Mobile units might be another way to reach families in more isolated communities with parenting, literacy, and health services.

7. Improving sources of information on service availability, use, and need

The FOCiS database is an important source of information on services families receive in the Healthy Beginnings system and referrals to providers outside the system. There may be more analyses we can do with the data systems currently available to understand how families enter and leave the system over time. At the same time, additional sources and analysis of information on the location of services, community needs for services, referral outcomes, and service participation would assist funders and service providers with planning and funding decisions. An integrated data system would, furthermore, make it easier to monitor use and outcomes of services in multiple systems.

In conclusion, to be effective, program policies and practices need to be grounded in the circumstances of the families they are intended to serve and take into account the multiple systems with which they interact. Services that have more flexibility to adapt to the circumstances of the low-income families they are intended to help might be more likely to reach these families and help to stabilize their daily lives. Families are less likely to use services, such as childcare, that do not fit with their daily routines, are not easy to get to, or do not fit with their work hours, or that conflict with their values. As we continue to learn more in the course of this study about families and services in the TGAs—including the reasons for service disparities, the needs of families, their sources of information about services, their service experiences, and the other factors that affect family functioning and children's development—we will learn more about how to strengthen community supports and design effective and flexible services and service delivery to fit the diverse needs and circumstances of these families.

INTRODUCTION

During the past several decades, considerable progress has been made in understanding the ecological and cultural context for children's development and, in particular, the harmful effects of poverty and its correlates on a range of child outcomes—physical, social, emotional, cognitive, and language—and family functioning (e.g., Bronfenbrenner, 1979, 1986; Brooks-Gunn, 2003; Gomby, 2005; National Research Council and Institute of Medicine, 2000; Olds et al., 2007; Weisner, 2002). At the same time, a variety of early intervention programs spanning the preschool years have been designed to ameliorate or moderate the effects of poverty on children's development and readiness for school. Increasingly, comprehensive, integrated service systems have been viewed as a promising strategy for supporting healthy family functioning and child development in low-income, at-risk families (Brooks-Gunn, 2003; Gomby, 2005; Olds et al., 2007). These early intervention programs and systems have had varying levels of impact on children and their families, with stronger impacts shown by multi-generational programs aimed at both parents and children.

Over the course of several years, the Children's Services Council (CSC) of Palm Beach County, Florida, in collaboration with service providers and other stakeholders, has been building an integrated system of care to promote and support the healthy development of children from birth to 8 years of age. Although the aim is to create a comprehensive system of services for the entire county, CSC and other stakeholders recognized the negative consequences of poverty on child development. Therefore, this effort began with a set of prevention and early intervention programs and systems serving families and their young children in four targeted geographic areas (TGAs)—the Glades, Lake Worth/Lantana, Riviera Beach/Lake Park, and West Palm Beach—that have high levels of poverty, teen pregnancy, crime, and child abuse and neglect.[5]

This is the third report of a longitudinal study commissioned by CSC to examine the use of this service system and its effects on children and families. This chapter presents an overview of the Palm Beach County service system and the design of the study. The remaining chapters present third-year findings based on interviews with and administrative records on mothers in the TGAs who gave birth during 2004 and 2005.

The Palm Beach County System of Care

The growing infrastructure of services for families and children in Palm Beach County is designed to support children at different stages of their early development through the provision of both direct services and supports to improve the quality of those services. The direct service system includes the following programs and systems, which are targeted to specific populations:

- The Healthy Beginnings system is a network of health and social services, based on the Healthy Start initiative, which provides a range of support and intervention services. These

[5] For example, according to the 2003 *State of the Child in Palm Beach County*, 75 to 93 percent of children in the TGAs receive free or reduced lunch; the rate of child abuse and neglect is between 4.1 and 6.6 times the county average; and crime rates in the TGAs range from 14 to 93 percent above the county rate.

services include universal risk screening before and after birth; targeted assessment and home visitation to high-risk pregnant women and new mothers; and coordinated services to families experiencing medical, psychological, social, and environmental risks that negatively impact pregnancy and birth outcomes.

- The Early Care and Education system comprises several initiatives intended to identify and provide services for children with developmental delays and improve children's school readiness.
- School behavioral health programs, including the Children's Behavioral Health Initiative (CBHI), are designed to improve children's adjustment to school and enhance their school success by identifying social-emotional and other developmental problems and providing referrals and interventions to respond to these problems.
- A network of afterschool programs for elementary and middle-school youth is supported by Prime Time, an intermediary working to develop the quality of afterschool activities in school-based and community programs.[6]

In addition, the service system in Palm Beach County also includes initiatives to improve the quality of social services and early childhood and afterschool programs and families' access to them. The service system also includes a group of universal supports available to a broader range of families, including parent education, mentoring, and family literacy programs.

The Palm Beach County system of care is based on an ecological framework. According to current developmental theory and research, children develop within a social and cultural context (Bronfenbrenner, 1986; National Research Council, 2000; Weisner, 2002). In their early years, the family is the primary context for children's development. What and how children learn and how they respond to people and events in their daily lives depend very much on the quality of the care they receive, their relationships with parents and other family members, and their home environments. At the same time, children's development is also influenced directly or indirectly by other environments, including their neighborhoods, childcare and school settings, their parents' workplaces, and, ultimately, the broader social, political, and economic landscape.

The major goals for the system are to increase the number of healthy births, to reduce the incidence of child abuse and neglect, and to increase school readiness, as indicated by the number of children who enter kindergarten ready to learn.[7] These goals are based on the assumption that strengthening the system of community supports and services available to families in the TGAs will enhance families' abilities to raise their children in healthy ways and, in turn, improve children's development and well-being. With improved family functioning and improved child health and development, it is further expected that children will be better prepared for school and families will be better able to support them in school. Moreover, it is believed that by strengthening the system of informal community supports and prevention and early intervention services, families are less likely to need more intensive mental health, child welfare, and juvenile justice services.

---

[6] Until December 2007, these programs and systems were supported by the Family and Community Partnership (FCP), which sought to enhance communication among providers and facilitate service integration as well as identify unmet service needs in the TGA communities.

[7] "Palm Beach County's Pathway to Early Childhood Development," CSC draft planning document, August 2007.

The Palm Beach County Longitudinal Study

A central question for CSC and other stakeholders in Palm Beach County concerns the effectiveness of the system. Is the service system functioning and being used by families as expected? Is it achieving its intended outcomes? Separate evaluations have been conducted on several individual programs and networks that are part of the system (e.g., Lyons, Karlstrom, & Haywood, 2007; Spielberger et al., 2005). However, these evaluations alone cannot provide information on how families use the *system* of services or the effects of multiple services on children's well-being and development. The goal of the longitudinal study is to describe the characteristics and needs of families the service system is intended to serve, how they use the services that make up the service system in Palm Beach County, and how service use is related to indicators of child well-being and family functioning, and child and family outcomes. It addresses questions in three key areas:

- What services and supports are available and how are they used by families of young children in the TGAs? Are there patterns of service use?
- What are the correlates of service use, including demographic and other family characteristics, indicators of risk and service need, geographic location, nativity, and prior service use?
- How does service use relate to children's school readiness, school success, and physical, social-emotional, and behavioral health; and to family functioning, rates of abuse and neglect, and parent involvement in schools?

In addition, we are also interested in learning how individual services and systems function as a comprehensive system of care. Thus, other important questions are whether the availability of a more complete array of services changes the way services are provided to families or makes individual programs more effective; and whether families experience larger effects from the use of an array of services than from the use of individual services.

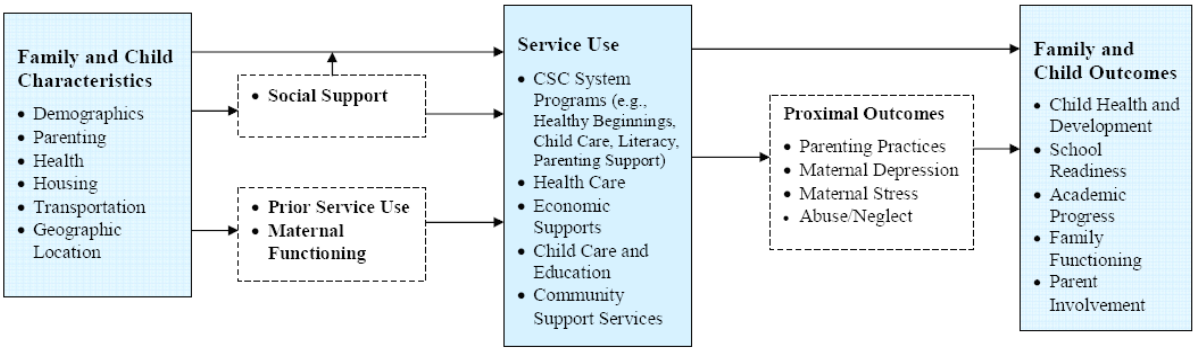
Conceptual Framework for Study

We use an ecological model to guide this study. As described above, the Palm Beach County system of care is being built on the premise that families in the TGAs will function better and be better equipped to raise their children to be healthy and ready for school—cognitively, socially, emotionally, and physically—with the support of a system of prevention and early intervention programs. This premise is reflected in the conceptual framework for the longitudinal study shown in Figure 1.

This model assumes that the families' access to and use of the system of care will affect proximal outcomes (e.g., parenting practices, maternal functioning, and reports of child abuse and neglect), which, in turn, will affect children's long-term outcomes. The model also suggests that service use is influenced by a number of factors, including child, family, and community characteristics, but also by maternal functioning and use of other services. For example, preliminary findings indicate that service use differs as a function of demographic characteristics such as age, education, employment, as well as individual beliefs and attitudes about services, perceptions of need and the costs of service use, and willingness to seek help (Spielberger et al.,

2007). In addition, mothers may be more likely to use services if their prior experiences with services were positive, or if the services used are a source of information about other services. Moreover, the conceptual framework suggests that the relationship between child and family characteristics and service use may be modified by the availability of social support.

Fig. 1. Conceptual Framework for the Palm Beach County Longitudinal Study



These are examples of the kinds of relationships examined in this third report. The purpose of the longitudinal study is to understand these complex relationships by gathering data from a variety of perspectives, using diverse data collection and analytic methods, and tracking specific subpopulations over time to determine whether patterns differ for different groups of people. This information is necessary to improve the functioning of the service system and its effects on children and families.

Study Design and Methods

In order to examine the use and effectiveness of the service system in Palm Beach County on children's early development and school readiness, it is important to track families during the early years of a child's life when they are most likely to come into contact with the service system. Thus, we selected as our primary study group families with newborns living in the TGAs, with the intent of following them for at least 8 years into the children's early school years. The study uses a mixed-methods approach to examine the relations among the service systems in Palm Beach County, indicators of child well-being and family functioning, and child and family outcomes. Methods include the following:

- An analysis of administrative data on service use and key outcomes for all children born in the TGAs and in the county during 2004 and 2005 and who remain in the county at various data collection points during an 8-year period. Administrative data analyzed for the third year came from the Department of Health (DOH) Vital Statistics database, the FOCiS database for the Healthy Beginnings system, and the Department of Children and Families (DCF) HomeSafenet database on reports of child abuse and neglect.
- An 8-year longitudinal survey of the service use experiences of a sample of families with young children in the TGAs. Methods include annual in-person interviews with a baseline sample of 531 mothers of newborn children and brief phone interviews with the

same parents about 6 months after each interview for a period of 5 years, as well as analysis of administrative data on service use and child and family outcomes for 8 years. A total of 399 mothers were interviewed in the third year.

- A 3-year embedded qualitative study involving in-depth interviews and observations of a small sample of forty families to enhance what is learned through analysis of structured interviews and administrative data about service use, motivations to use services, and how services fit into families' lives.

The study's comprehensive, longitudinal design will allow us to examine in depth the relations among child and family characteristics, use of the service system, and child and family outcomes. It will also allow us to suggest explanations for any relations that are found and document changes that occur within families over time that might be attributable to use of particular services. We briefly describe the three primary sources of data for the study below. Appendix A, as well as the first-year report (Spielberger et al., 2006) provides other information about the study design and methodology.

Administrative Data

The longitudinal study is collecting and analyzing administrative data on family characteristics, service use, and key outcomes on a birth cohort of 30,133 children who were born in Palm Beach County in 2004 and 2005, and a subgroup of 15,588 of those children who were born in the TGAs during that period.[8] The study will follow these children and their families as long as they remain in the county at various data collection points during the 8-year study period.

In this report, data from several sources of administrative data were examined. First, the Department of Health (DOH) Vital Statistics database provided information on the use of prenatal care, birth outcomes, and maternal demographic characteristics. Second, the FOCiS database for the Healthy Beginnings system provided information on prenatal and postnatal assessments, names of agencies providing maternal child health services, types of services, and dates of service received from 2004 through 2006. Third, the Department of Children and Families (DCF) HomeSafenet database supplied information on reports of child abuse and neglect in 2004 and 2005.

Structured Interviews

The study also involves more intensive data collection on a sample of families in the TGAs with children born in 2004 and 2005. This sample, which was recruited through two maternal health programs in Palm Beach County, the Healthy Mothers/Healthy Babies Coalition and Healthy Start,[9] was stratified along two dimensions. First, based on the assumption that families with

[8] The number of births in the county and TGAs includes multiple births. There were 29,622 mothers in the county and 12,438 in the TGAs who gave birth in 2004-2005, according to the Vital Statistics database.

[9] We followed this approach as an alternative to obtaining permission to sample from birth records for several reasons. First, we did not know whether we would be able to obtain Institutional Review Board (IRB) approval under the Health Insurance Portability and Accountability Act (HIPAA) to use protected health information for sample identification and recruitment. We also were following the precedent of an earlier study about access to prenatal care in Palm Beach County (Tandon, 2004), which recruited and interviewed newly delivered mothers in

more risk factors were more likely to have contact with services, we attempted to develop the sample so that about half would be families identified as "at risk" (indicating families at higher risk of dysfunction than other families or children at higher risk of poor outcomes than other children) on a hospital screen or home assessment. Second, because the Glades TGA is sparsely populated and historically more transitory than other areas of the county,[10] we wanted to ensure that the Glades sample was large enough to make reasonable estimates of its characteristics.

Thus, the overall sample was structured so that about half of the sample was composed of mothers screened "at risk" and 20 percent of the sample were mothers residing in the Glades TGA. Although mothers were to have recently given birth to a child and have custody of that child, their babies did not have to be first-born children. Other selection criteria included maternal age and language. Mothers also had to be at least 16 years old and speak English, Spanish, or Haitian Creole to participate in the study.

Each year, mothers are interviewed in person for about an hour to an hour and a half, usually in their homes. Six months after an in-person interview, they participate in a brief telephone interview lasting 20 to 30 minutes. The baseline interviews were conducted soon after recruitment when the recently born child—referred to here as the "focal child"—was between 1 and 6 months of age. Telephone interviews occurred 6 months later when the focal child was between 7 and 12 months old. The third interview, another in-person interview, occurred when the focal child was between 13 and 18 months of age. Another telephone interview occurred 6 months later when the focal child was between 19 and 24 months old. The fifth interview was another in-person interview, which occurred when the focal child was between 25 and 30 months of age. All of these interviews were conducted by trained interviewers employed by Westat. Mothers were paid $25 for each of the first two in-person interviews and $35 for subsequent in-person interviews.

In reporting the results, we refer to the annual interviews conducted with the study sample as either the *study sample interviews* or *surveys*. Topics for the first 3 years of in-person interviews are listed in Table A-2 in Appendix A. These topics were developed by Chapin Hall researchers with input from CSC and Westat as well as with reference to protocols used in other large-scale evaluations and studies of service use, children's development, and family functioning.[11] The in-person interviews cover a wide range of topics in an effort to develop a complete description of the demographic characteristics of families and other factors that are likely to affect family functioning and children's development. A copy of the year 3 in-person interview can be found in Appendix A.

---

maternity wards. Finally, we recognized that because of their experience working with mothers in the TGAs, the hospital liaisons and nurses might be more trusted by potential respondents than other recruiters.

[10] The Glades TGA, in the western part of the county, is a large but sparsely populated agricultural area that includes migrant families who harvest sugar cane, citrus fruit, and other crops. According to data from the 2000 Census, the percentage of families with children under the age of 18 living in poverty is higher in the Glades (46%) than in the other TGAs (25%) and in the county as a whole (13%) (CSC, May 2006).

[11] Other studies include the national evaluation of Family Preservation and Reunification Programs (Westat, Inc., Chapin Hall, & James Bell Associates, 2002), the Early Childhood Longitudinal Study (NCES, 2002), and the evaluation of the Cuyahoga County Early Childhood Initiative (Daro et al., 2003).

In any longitudinal study—especially one involving low-income families who are likely to be more mobile than other families and may not have functioning telephones—sample attrition is to be expected. Of the 531 mothers in the baseline sample, 444 (84%) completed the second-year in-person interview, and 399 (75%) completed the third-year in-person interview. A total of 390 (73%) of the mothers participated in all three waves of in-person interviews. To date, most of this sample attrition has been because mothers could not be located or had moved out of the study area. Only a small percentage of mothers have declined to participate in follow-up interviews or left the study for other reasons. A regression analysis of the mothers who completed the second- and third-year interviews indicates that this attrition is almost random. In year 2, the only significant variable was marital status: mothers who were married were about twice as likely to be interviewed in year 2 as mothers who were not. In year 3, the only significant variable was ethnicity: African-American mothers were 2.5 times as likely as mothers of other ethnic backgrounds (largely Hispanic) to be interviewed in the third year. (Appendix A provides information on the number of mothers recruited, the number of completed interviews as of May 15, 2008, and study attrition.)

Qualitative Interviews

We added an embedded qualitative study of a small subsample of families in the spring of 2006. This study is designed to provide a more in-depth and complete understanding of how families experience, perceive, and use services in the context of their daily lives and the processes by which family and community contexts influence children's development and school readiness. Open-ended, semi-structured interviews—referred to in this report as the *qualitative interviews*—examine families' perspectives on the following topics: daily routine and household information; beliefs, goals, and practices about child rearing; experiences with educational and childcare services; work, economic well-being, and use of income support programs; use of health care and social services; and mobility and neighborhood characteristics. The format for the qualitative interview is based on the Ecocultural Family Interview framework (Ecocultural Scale Project, 1997; Weisner, 1984). (Additional information about the methodology for the qualitative study can be found in Appendix A.)

Qualitative interviewers meet with families twice a year to conduct in-depth, semi-structured interviews that last about 90 minutes. All interviews are tape-recorded with the permission of mothers, transcribed, and validated to confirm the accuracy of the transcription. In the case of interviews conducted in Spanish, translation is carried out concomitantly with transcription. Interviewers also write detailed summary notes of the information collected during the interview and their observations of the home and neighborhood environment, parent-child interactions, and child behavior.

Using a mixed-sampling plan, we randomly selected fifty-eight English- and Spanish-speaking mothers from the full study sample; fifty-one mothers were located and agreed to participate in either the first or second qualitative interview. Because the qualitative study started a year after the larger study and we wanted to interview mothers when their children were young, we limited the sample pool to mothers whose babies were born in 2005. We also excluded Haitian Creole-speaking mothers from the qualitative sample because they are a small proportion of the larger sample, and we did not have resources to hire a Creole-speaking

interviewer. Thus, we divided the sample pool by initial risk level and then sampled Glades and non-Glades mothers in proportion to their representation in the larger study. (See Appendix A for additional information about the qualitative methodology.)

Tables B-3 and B-4 in the Appendix compare characteristics of the qualitative sample with the characteristics of the larger survey sample. For the most part, the qualitative study sample paralleled the larger sample of 531 mothers in terms of risk status, TGA, and ethnicity. However, the qualitative sample has a somewhat higher proportion of mothers who were screened "at risk" (52% versus 42%), were Hispanic (58% versus 52%), were married (28% versus 24%), and had family incomes greater than $20,000 in the previous year (40% versus 34%) at the time of the baseline interview. The qualitative sample also had a somewhat lower proportion of high school graduates (32% versus 40%); the mothers in the qualitative sample were less likely to be working (6% versus 14%) and were less likely to live in families that owned their homes (16% versus 20%) than those in the larger study sample in Year 1.

As with the larger sample, there has been attrition among mothers in the embedded qualitative study who have moved out of the study area, cannot be located, or, in a few cases, have refused to be interviewed (see Appendix A). Initially, we conducted interviews with fifty-one mothers at either the first wave or second wave; forty-six mothers were interviewed in the first wave between May and July 2006, and forty-two were interviewed in the second wave between November 2006 and January 2007. Thirty-seven mothers were interviewed in the third wave, and thirty-five in the fourth wave. We are currently following and trying to retain forty mothers in the qualitative sample, though we have not been able to interview all of them in all waves of the study.

Organization of This Report

This third-year report presents findings from the third year of in-person interviews conducted when the focal child was between 24 and 30 months of age and makes comparisons with findings from the first and second year. In all analyses, we use 390 as the sample population, which is the number of mothers who completed all three waves of the in-person interviews. This report also draws on administrative data from FOCiS, Vital Statistics, and DCF for information on the family characteristics and service use of the study cohort. These data are augmented with additional information drawn from the first three waves of qualitative interviews about the economic circumstances of families in the sample, their health, parenting beliefs and practices, social support, and barriers to and facilitators of service use.

The next chapter, Chapter 2, begins with an overview of the dominant demographic characteristics of the 2004-2005 birth cohort. We then present in Chapter 3 a description of the characteristics of the 390 mothers who participated in all three years of in-person interviews, including their demographics, health, living conditions, and their children's health and development. In Chapter 4, we describe mothers' reports of their parenting activities and those of their husbands or partners. In Chapter 5, we discuss findings on families' experiences with childcare and the factors that affect their use of childcare. In Chapter 6, findings on informal and community supports are presented. In Chapter 7, we report on families' use of Healthy Beginnings and other formal services by drawing on administrative data and mothers' self-

reports. We go on, in Chapter 8, to examine the patterns and correlates of service use in year 3 and, in Chapter 9, to discuss findings related to the barriers to and facilitators of service use emerging from our qualitative data. In Chapter 10, we present early findings on the relationships between service patterns and maternal functioning and child development. In the final chapter, Chapter 11, we summarize the findings and consider their implications for the Palm Beach County service system.

FAMILY CHARACTERISTICS

In this chapter, we begin with a summary of the demographic characteristics of the 2004-2005 birth cohort, based on an analysis of Vital Statistics data, and compare them with the characteristics of the cohort of mothers who gave birth in 2006-2007. We then describe in detail the characteristics of the year 3 sample, composed of 390 mothers who participated in all three of the in-person structured interviews, including their demographics, living conditions, and health characteristics. The descriptive data for the sample were weighted in the analyses to account for the over-sampling of mothers from the Glades and mothers who were identified as being "at risk" on the hospital screen or home assessment.

The 2004-2005 Birth Cohort

Table 1 presents characteristics of the cohort of mothers who gave birth in Palm Beach County in 2004 and 2005, from which the study interview sample was drawn. As shown in Table 2, mothers in the TGAs were more likely than mothers outside the TGAs to be Black or Hispanic, to be unmarried, to have less than a high school education, and to have a low-birth-weight baby.[12]

Table 1. Characteristics of Mothers with Newborns, 2004-2005[a]

Characteristic	Palm Beach County (*N* = 29,622)	Non-TGAs (*n* = 17,184)	TGAs (*n* = 12,438)	Year 3 Survey Sample at Baseline (*n* = 390)[b]
Not Married (%)	40	27	57	73
Teen Mother (%)	9	6	14	17
< HS Education (%)	22	13	35	53
Black[c] (%)	26	18	36	38
Hispanic[c] (%)	29	22	39	55
Foreign-Born (%)	41	36	47	57
Used WIC While Pregnant (%)	35	23	52	72
Low-Birth-Weight Baby (%)	8	8	9	11
Study Risk Index Mean (*SD*)[d]	2.5 (*1.8*)	2.0 (*1.7*)	3.1 (*1.7*)	4.1 (*2.0*)

[a] Source: Vital Statistics and survey data. Sample numbers exclude mothers who gave birth in Palm Beach County but were residents of other counties. Mothers who had multiple births were counted once.

[b] Survey data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk." Survey sample description is based on survey data rather than Vital Statistics, except for WIC use and baby's birth weight, so characteristics can be tracked over time. Both data sources were generally consistent, except for education; Vital Statistics data indicated that 55 percent of the survey sample had not finished high school.

[c] To be consistent with the racial/ethnic categories in the survey, "Black" denotes non-Hispanic mothers who identified themselves as "Black," "Haitian," or "Haitian and Black"; mothers identified as "Haitian and Hispanic" were coded "Hispanic."

[d] Because not all mothers in the county were screened at birth, we calculated a risk index based on their number of eleven demographic and health characteristics recorded in Vital Statistics. These were the following: (1) no or late prenatal care, (2) mother does not have high school diploma or GED, (3) mother is not married, (4) mother age 19 or less at birth, (5) mother not born in U.S., (6) mother received WIC while pregnant, (7) mother smoked, (8) mother had medical complications (other than previous C-section), (9) mother had delivery complications, (10) baby's weight less than 2500 grams, and (11) baby's gestational age 36 weeks or less.

[12] Within the TGAs, the Glades had the highest proportion of unmarried and teen mothers. Whereas large proportions of mothers in Lake Worth and West Palm Beach were foreign-born (62% and 50%, respectively) and Hispanic (46% and 34%, respectively), mothers in the Glades and Riviera Beach were predominantly U.S.-born and Black (Spielberger et al., 2007).

Almost half (47%) of the mothers in the TGAs who gave birth in 2004 and 2005 were foreign-born. The largest percentages of foreign-born mothers in the TGAs came from Mexico (9%), Haiti (8%), and Guatemala (7%); 16 percent came from other Caribbean, Central American, and South American countries, and 6 percent came from other countries.

As described in previous study reports, the interview sample has a somewhat higher proportion of mothers with demographic risk factors than the 2004-2005 TGA birth cohort.[13] For example, Table 1 shows that more than half (59%) of the study sample had less than a high school education compared with just over a third (35%) of the TGA birth cohort.[14] Seventy-two percent of the study sample were unmarried at the time of the baseline interview compared with 57 percent of the TGA birth cohort. In addition, the percentages of mothers in the study sample who were foreign-born, Black, and Hispanic were higher than the percentages in the TGA cohort. More than one-half (55%) of mothers in the survey sample were Hispanic, and 37 percent were non-Hispanic Black. More than half (57%) were foreign-born, with the largest percentages coming from Mexico (19%), Guatemala (13%), and Haiti (7%) (see Table 3).

For comparison purposes, we also analyzed administrative data on the cohort of mothers who gave birth during the subsequent year, 2006. These results, presented in Table 2, suggest that there were some differences between mothers who gave birth in 2004-2005 and mothers giving birth in 2006. Notably, there was an increase in the percentage of Hispanic mothers, which grew from 29 percent in 2004-2005 to 33 percent in 2006 in the county and from 40 percent to 43 percent in the TGAs. The percentage of mothers identified as Black fell during the same time period. There were only small differences in other characteristics. The percentage of

Table 2. Characteristics of Mothers with Newborns, 2006[a]

Characteristic	Palm Beach County (*N* = 15,433)	Non-TGAs (*n* = 8,717)	TGAs (*n* = 6,716)
Not Married (%)	43	29	60
Teen Mother (%)	9	6	14
< HS Education (%)	25	15	38
Black (%)	25	18	34
Hispanic (%)	33	25	43
Foreign-Born (%)	43	38	48
Used WIC While Pregnant (%)	36	24	51
Low-Birth-Weight Baby (%)	8	7	9
Study Risk Index Mean (*SD*)	2.5 (*1.8)*	2.0 (*1.7*)	3.1 (*1.8*)

[a] Source: Vital Statistics

[13] Although we weighted the data to adjust for the oversampling of mothers from the Glades and "at risk," it should be noted that the recruitment process, which relied on the two largest maternal health organizations in the county, was imperfect. Recruiters could not contact *all* mothers who gave birth in 2004-2005, and not all groups of mothers agreed to participate at the same rates (Spielberger et al., 2006). Thus, the interview sample still has higher proportions of some risk characteristics, a higher proportion of Hispanic foreign-born mothers, and a lower proportion of Haitian mothers than the 2004-2005 TGA birth cohort.

[14] Vital Statistics data indicated that a somewhat smaller percentage (55%) of the survey sample had not finished high school. However, we decided to use the survey data for this descriptor so that we could track educational levels over time.

foreign-born mothers giving birth was slightly higher in 2006 compared with 2004-2005. The percentages of new mothers who were unmarried and who had less than a high school education also grew slightly in 2006 across the county.

The Year 3 Study Sample

Table 3 presents the baseline characteristics of mothers in the year 3 study sample, and Table 4 shows changes in selected family characteristics over time. The most noteworthy change was an increase in the proportion of mothers who were working. At baseline, just 13 percent of the sample mothers were working part-time or full-time, whereas nearly half (49%) were working at the time of the third interview. There were additional, modest changes in family income, educational levels, community of residence, and marital status over time. These changes are described below.

Household Characteristics

At the beginning of the study, based on weighted data, 13 percent of the sample families lived in the Glades TGA and 87 percent lived in the other three TGAs. Over the 3 years of the study, there has been a modest increase in the percentage of study families who now live outside the TGAs (6% in year 2, and 10% in year 3). Most of this movement has come from families in the non-Glades TGAs; in the third year, 78 percent lived in the non-Glades TGAs, compared with 87 percent in the first year.[15] The proportion of families who live in the Glades has been fairly stable (13 percent in the first and second years, 12 percent in the third year).

The proportion of married mothers increased slightly from year 1 (27%) to year 2 (30%) but did not change between year 2 and year 3 (30%). The percentage of mothers who were single and living with a partner, however, declined from 40 percent to 33 percent from the first to the third interview, while the percentage of mothers who were single and not living with a partner increased from 20 percent to 26 percent during that time period. Forty-three percent reported that, although unmarried, they were in a relationship with a partner, and 63 percent said they were currently living with their husband or partner.

In terms of family composition, the proportion of mothers with two or more children increased by 11 percentage points over the first 3 years. At the time of the third in-person interview, 33 percent of the sample had one child, 34 percent had two, and 33 percent had three or more. Ninety-four mothers (24%) reported that they had had another child since the birth of the focal child.[16] Twenty-nine (8%) mothers were pregnant at the time of the year 3 interview; for four of these mothers, this was the second pregnancy since the birth of the focal child. Just a third (33%) of the mothers had only one child at the time of the year 3 interview, and 34 percent had three or more children. Ten percent reported they had other children under the age of 18 who were not living in their households. Household sizes at the time of the interview ranged

[15] A majority of the mothers living outside the TGAs had moved to one of two areas adjacent to the West Palm Beach and Lake Worth/Lantana TGAs (zip codes 33415 and 33435).

[16] By comparison, according to a Center for Disease Control and Prevention report (2005), in 2002 the interval between first and second births was less than 12 months for 5 percent and between 13 and 24 months for 23 percent of low-income (defined as 0%-149% of poverty level) mothers ages 20-44.

from one to twelve members in the third year, with an average of five members per household. Two mothers reported that their children were living with another relative when they were interviewed, although they expected them to return home in the next 6 months. One said that she was both in school and working, and the other said she had just moved and needed to get settled before her child could live with her again.[17]

Table 3. Baseline Characteristics of Mothers in Year 3 Sample[a]

Characteristic	Year 3 Sample at Baseline (*N* = 390)
TGA (%)	
Glades	13
FOCiS initial risk screen (%)	
At risk/high need screen score	31
Study Risk Index (Vital Statistics)	
Mean (*SD*)	3.6 (*1.5*)
Range	0-8.0
Age of mother	
Mean age (*SD*)	25 (*5.7*)
Age range	15-43
Teen mother at child's birth (%)	
Age 15–19	17
Mother's race (%)	
Hispanic	55
Black, not Hispanic	38
White, not Hispanic	5
Other or multiracial	2
Main language spoken in home (%)	
English	44
Spanish[b]	48
Haitian Creole, Kanjobal, other[b]	9
Mother's nativity (%)	
United States	43
Mexico	19
Guatemala	13
Haiti	7
Other Caribbean, Central or South American country	17
Mother's education (%)	
Less than high school diploma/GED	59
High school graduate	41
Mother's employment (%)	
Employed full- or part-time	13

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Mothers whose primary language was not English were asked how well they spoke English; 21 percent said they spoke it "well" or "very well"; 42 percent said they spoke it "a little"; and 37 percent said they spoke English "not at all" in year 3.

[17] Although mothers who lose custody of their children do not remain in the study, mothers who report temporary separations from their children are retained, even if they are unsure about when their children will return.

Parental Employment and Education

The most marked change during the first three years of the study occurred from the first to the second year, when maternal employment rose from 13 percent to 45 percent. Maternal employment grew just slightly from the second to the third year, when it stood at 49 percent. About a third of the sample appeared to be steadily employed for at least two of the data collection periods. That is, 10 percent were employed at all three time points, and 24 percent were not employed at the time of the first interview but were employed at the time of the second and third interviews. An additional 15 percent were unemployed at the first two interviews but were employed at the time of the year 3 interview. Approximately a third (34%) of the sample were unemployed at all three interviews. The remaining 17 percent have been sporadically employed.

Of those who reported being employed at any one time, most reported that they were working full-time. In the third year, more than three-fourths (79%) of the mothers who were employed reported working 30 hours or more per week, with an average number of 35 hours per week. Most mothers worked one job; only eleven reported having two jobs. More than two-thirds (73%) of the working mothers described their job as a regular daytime shift, and another 15 percent reported working a regular evening shift. Rotating shifts were reported by 9 percent of the mothers, regular night shifts were reported by 1 percent of the mothers, and 2 percent of the mothers reported working either a split shift or some other schedule. The largest group (54%) of mothers described their work as a "service" occupation, and 15 percent reported being in an administrative position. Smaller percentages (7% or less) of working mothers described their jobs as being agricultural, production, marketing/sales, or nursing positions.

Paternal employment has remained fairly stable over the 3 years, ranging from 87 percent in the first year, to 91 percent in the second year, to 89 percent in the third year. As a result, when looking at both family structure and employment over time, we see a sizeable increase in the percentage of two-parent households in which both parents are working (from 5% in the first year to 23% in the second and third years). We also see an increase in the percentage of single-parent households with a working parent (from 8% in the first year to 20% in the second year and 24% in the third year).

Mothers continued to report relatively low levels of education in the third year of the study in that less than one-half (45%) had graduated from high school. At the same time, there was a slight increase in the percentage of mothers reporting some additional education beyond high school, from 17 percent in year 1 to 23 percent in year 3. There also was a small increase in the percentage of husbands or partners who had graduated from high school in year 3.[18]

[18] In a small number of families, there were some changes in who the mother identified as her partner, so some of this increase may reflect a new partner. Thus, in year 1, in all but three cases husbands or partners living in the household were the fathers of the focal child. In year 2, in all but fourteen cases, husbands or partners living in the household were the fathers of the focal child. In year 3, in all but eleven cases, husbands or partners living in the household were the fathers of the focal child.

Table 4. Household Characteristics at Year 1, Year 2, and Year 3[a]

Characteristic	Year 1 (*N* = 390)	Year 2 (*N* = 390)	Year 3 (*N* = 390)
TGA* (%)			
Glades	13	13	12
Non-Glades	87	81	78
Outside TGAs	--	6	10
Marital Status* (%)			
Married, living with husband	27	30	30
Married, not living with husband	1	0	1
Single[b], living with a partner	40	37	33
Single, in a relationship but not living with partner	12	10	10
Single, not in a relationship	20	23	26
Number of Children* (%)			
One[c]	44	42	33
Two	30	34	34
Three or more	26	25	33
Mean *(SD)* Age of Focal Child in Months	2 *(1.1)*	14 *(2.9)*	26 *(1.6)*
Husband/Partner[d]			
Mean age (*SD*)	28 (*6.5*)	29 (*6.4*)	30 (*6.3*)
High school graduate (%)	35	39	40
Currently employed (%)	87	91	89
Household Size (Children and Adults)			
Mean (*SD*)	5 (*1.8*)	5 (*1.7*)	5 (*1.8*)
Range	2-11	2-11	1-12[e]
Family Structure and Employment* (%)			
Two-parent household and one parent works	58	43	37
Two-parent household and both parents work	5	23	23
Two-parent household and neither parent works	5	1	2
Single-parent household and parent works	8	20	24
Single-parent household and parent does not work	26	13	14
Mother's Employment* (%)			
Currently employed full- or part-time	13	45	49
Mother's School Attendance (%)			
Currently attending school	9	8	11
Mother's Education Level* (%)			
Less than high school diploma	59	56	55
High school diploma or GED	24	23	22
Post-high school education	17	22	23

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] "Single" includes mothers who identified themselves as single, never married, divorced, separated, or widowed.
[c] Four percent of mothers reported having had a child subsequent to the focal child at the year 2 interview, and 24 percent at year 3, but because of other changes in the number of children living in the households, there was only a 2-percent difference between year 1 and year 2, and a 9 percent difference between year 2 and year 3.
[d] In year 1, in all but three cases, husbands or partners living in the household are the fathers of the focal child. In year 2, in all but fourteen cases, husbands or partners living in the household are the fathers of the focal child. In year 3, in all but eleven cases, husbands or partners living in the household are the fathers of the focal child.
[e] Two children were not living with their mothers at the time of the year 3 interview but were expected to return within 6 months.
*Paired sample *t*-tests indicated that the following year-to-year differences were statistically significant: TGA1 vs. TGA2 ($p < .001$); TGA2 vs. TGA3 ($p < .01$); Marital status1 vs. Marital status3 ($p < .01$; Marital status2 vs. Marital status3 ($p < .05$); Number of children1 vs. Number of children3 ($p < .001$); Number of children2 vs. Number of children3 ($p < .001$); Family structure1 vs. Family structure2 ($p < .000$); Maternal employment1 vs. Maternal employment2 ($p < .001$); Maternal education1 vs. Maternal education2 ($p < .001$); Partner employment1 vs. Partner employment2 ($p < .05$); and Partner employment2 vs. Partner employment3 ($p < .05$).

In addition, 11 percent of the mothers also said they were currently in some kind of educational program, either full-time or part-time, a small increase from the 8 percent reported in the first year. About one-fifth of those currently in some kind of educational program reported being in a vocational or technical program, another fifth reported being in an English as a Second Language program, and another fifth reported being in a 4-year or bachelor's degree program. Smaller percentages of mothers reported being in one of the following: 2-year or associate's degree program (14%), GED program (10%), high school program (9%), a master's degree program (5%), or a job training program (2%).

Family Income and Economic Support

Corresponding to the increase in maternal employment, the percentage of mothers who reported family incomes less than $20,000 declined from 67 percent to 50 percent in the second and third years (see Table 5).[19] The percentage of mothers who reported living in a home owned by a family member remained steady from year 2 to year 3 at 24 percent, a modest increase from 19 percent in the first year. An income-to-need ratio was calculated using the entire household size, the number of children under age 18, and the federal poverty thresholds. In year 1, 71 percent of our sample reported incomes that suggested they were living at or below the federal poverty threshold for the previous year; in year 2, the percent of those living at or below the threshold dropped to 55 percent. The income-to-need ratio remained fairly constant in year 3, with 54 percent of the families living at or below the federal poverty threshold for the previous year.[20]

At the same time, use of income support programs has declined over time. Although use of food stamps increased from 36 percent in the first year to 45 percent in the second, it dropped in the third year to 34 percent. We also saw a significant decline in use of the WIC program from 86 percent in year 1 to 81 percent in year 2 and 60 percent in year 3. Only 3 percent of the families reported receiving TANF, which was a decline from the 6 percent reported in the first 2 years of the study. Only the percentage of families who received vouchers for housing stayed the same across the 3 years. Some of these changes might reflect higher income levels from employment, which may render some study families ineligible for support; but they may also reflect other barriers to service use.

The survey also asked mothers about home ownership. A large majority (76%) continued to live in rented homes in the third year of the study. Although the percentage of mothers who reported living in a home owned by a family member rose from year 1 to year 2, the percentage did not change from year 2 to year 3.

---

[19] The survey asks mothers to estimate their "total household income from all sources" for the previous year in broad categories (i.e., $10,000-$19,999 and $20,000-$39,999); thus, we categorized families according to whether or not they were above or below $20,000. It should be noted that estimating income can be difficult when income is irregular and unstable (e.g., Edin & Lein, 1997). This was the case in some of the study families, in which fathers who worked in construction or landscaping could not work when it rained, lost wages if they had to take time off to take a mother or child to the clinic, and experienced frequent changes in the days and hours of their work.

[20] Because mothers were asked to estimate the income for the previous year, we calculated the income-to-need ratio based on the poverty levels for the preceding year that corresponded to the year the majority of the interviews were conducted each year. (For example, three-quarters of the sample was first interviewed in 2005, so we used the 2004 income threshold under the Federal Poverty Guidelines to calculate the ratio for year 1.)

Table 5. Family Income and Economic Support at Year 1, Year 2, and Year 3

Characteristic	Year 1 (*N* = 390)	Year 2 (*N* = 390)	Year 3 (*N* = 390)
Annual Income Previous Year* (%)			
Less than $20,000	67	50	50
Income-to-Need Ratio* (%)			
Ratio at or below poverty threshold	71	55	54
Use of Income Support Programs (%)			
Women, Infants, and Children (WIC)*	86	81	60
Food Stamps*	36	45	34
EITC	16	20	18
SSI	10	8	8
Temporary Assistance for Needy Families (TANF)*	6	6	3
Rent voucher	4	4	4
UI	3	2	1
Home Ownership* (%)			
Home owned by mother and/or other family member	19	24	24

[a] Data were weighted to adjust for the over-sampling of mothers in the Glades and mothers screened "at risk."
*Paired sample *t*-tests indicated that the following year-to-year differences were statistically significant at $p < .05$ or less: Income1 vs. Income2 ($p < .001$); Income-to-Need ratio1 vs. Income-to-Need ratio2 ($p < .001$); WIC1 vs. WIC2 ($p < .05$); WIC2 vs. WIC3 ($p < .001$); Food Stamps1 vs. Food Stamps2 ($p < .01$); Food Stamps2 vs. Food Stamps3 ($p < .001$); TANF2 vs. TANF3 ($p < .05$); and Home Ownership1 vs. Home Ownership2 ($p < .01$).

Sample Characteristics by TGA

As mentioned in the introduction, one question of interest is whether service use differs in the Glades, a distinct area in the western part of the county. Because it is a larger, more rural, and more remote area than areas in eastern Palm Beach County, funders and service providers want to ensure that families in this area are well served by the service system. Thus, in order to understand service use and the effects of service, it is important to understand the characteristics of families living in different parts of Palm Beach County. Subsequent analyses of the relationship between geographic location and service use and the effects of service use by location, for example, must take into consideration differences in the characteristics of the families who live in the Glades rather than other parts of the county.

Table 6 presents selected characteristics of families living in the Glades, the non-Glades TGAs, and outside the TGAs elsewhere in Palm Beach County at year 3. Statistically significant differences were observed between these groups of mothers in terms of their race/ethnicity, main language spoken at home, nativity, and relationship status. Specifically, mothers living outside of the Glades were more likely than those residing in the Glades to be Hispanic, and those living in the Glades were more likely to be Black. In addition, those living outside the TGAs were more likely than mothers in the other two groups to be White or of some other race. These differences were reflected in differences with respect to main language spoken at home and nativity. Thus, mothers living in the Glades were more likely than those living outside of the Glades to speak English, and those living outside the Glades were more likely to speak Spanish. Similarly, mothers living in the Glades were more likely to have been

Table 6. Selected Characteristics of Year 3 Sample Mothers by TGA[a]

Characteristic	Total (*N* = 390)	Glades (*n* = 48)	Non-Glades (*n* = 303)	Outside TGA (*n* = 39)
Right Track initial risk screen (%)				
At risk/high need screen score	31	29	32	26
Study Risk Index (Vital Statistics)				
Mean (*SD*)	3.6 (*1.5*)	3.7 (*1.6*)	3.7 (*1.5*)	3.4 (*1.4*)
Range	0-8	1-8	0-8	0-6
Age of mother				
Mean age (*SD*)	27 (5.7)	26 (*5.9*)	27 (*5.6*)	28 (*6.0*)
Age range	17-46	17-42	17-46	18-42
Teen mother at child's birth (%)	17	25	15	18
Mother's race/ethnicity (%) **				
Hispanic	54	29	58	54
Black, not Hispanic	38	69	34	28
White or other race	8	2	8	18
Main language spoken in home (%) **				
English	45	75	40	46
Spanish	48	23	52	49
Haitian Creole, Kanjobal, or other	7	2	8	5
Mother's nativity (%) **				
United States	41	77	34	50
Mexico	20	15	21	23
Guatemala	13	0	16	8
Haiti	7	2	8	5
Other country	20	6	22	15
Mother's education (%)				
Less than high school diploma/GED	55	46	58	45
High school graduate	22	29	21	23
Post high school education	23	25	22	33
Mother's employment (%)				
Currently employed	49	51	49	49
Marital status (%) **				
Married, living with husband	30	22	31	35
Single[b], living with partner	33	18	35	35
Single, in a relationship but not living with partner	10	16	10	8
Single, not in a relationship	26	41	25	23
Number of children (%)				
One	33	27	33	39
Two	34	29	37	18
Three or more	33	44	30	44
Household size (all children and adults)				
Mean (*SD*)	5 (*1.8*)	5 (*2.1*)	5 (*1.8*)	5 (*1.5*)
Range	1-12	1-12	1-11	2-8
Annual income previous year (%)				
Less than $20,000	50	65	48	42
Income-to-need ratio (%)				
Living at or below poverty threshold	54	68	53	49
Home ownership (%)				
Own home	24	29	23	28

[a] Data were weighted to adjust for the over-sampling of mothers in the Glades and mothers screened "at risk."
[b] Single includes respondents who identified themselves as either single, never married; divorced; separated; or widowed.
**Denotes variable for which one or more pairwise comparisons between groups were statistically significant ($p \leq .05$).

born in the United States than those living outside the Glades. Finally, mothers living in the Glades were more likely than non-Glades mothers to be single and without a partner, whereas non-Glades mothers were more likely than Glades mothers to be cohabiting.

Although in year 2 employment levels among mothers in the Glades were somewhat lower than among mothers in others part of the county, there were no differences in the third year. Mothers in the Glades continued to report lower household incomes, however, than those in the non-Glades and outside the TGAs. These differences may reflect, in part, that they are more likely to be single mothers. Sixty-five percent of mothers in the Glades reported annual family incomes of less than $20,000, whereas only 48 percent of the non-Glades mothers and 42 percent of mothers living outside the TGAs reported annual family incomes of less than $20,000 (however, these differences were not statistically significant at the 5-percent level). Also, approximately two-thirds (68%) of the Glades mothers had income-to-need ratios at or below the national poverty level compared with 53 percent for the non-Glades TGAs and 49 percent for mothers outside the TGAs.

Sample Characteristics by Nativity

Another important factor to consider in determining the effect of service use on family functioning and children's development is immigrant status. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act in 1996 prohibited most immigrants who had lived in the United States for less than five years from receiving public benefits such as Medicaid and Food Stamps (e.g., King, 2007). Findings presented in the second-year report of this study as well as a growing body of literature indicate that even among eligible groups of people, immigrants are less likely to take up these and other services than native-born individuals (e.g., Dinan, 2005a, 2005b). Given the growing population of immigrants in Palm Beach County, it is particularly important to examine service use in relation to the characteristics, experiences, and outcomes of immigrant families with young children in the county.

Table 7 presents selected characteristics of the sample families as a function of their nativity—mothers who were born in the United States, foreign-born mothers who have lived in the United States less than 5 years, and foreign-born mothers who have lived in the United States for 5 years or more. Along with the ethnic/racial and TGA differences between the two groups, we found statistically significant differences in education, marital status, and use of income support programs. Foreign-born mothers were more likely to be married (40%) or to be single and living with a partner (40%) than native-born mothers (17% and 22%, respectively). On the other hand, native-born mothers were more likely to have a high school education or above. There were no differences in the percentages of native-born and foreign-born mothers living at or below the poverty level. However, immigrant mothers were more likely to use WIC than native-born mothers (71% vs. 46%), whereas native-born mothers were more likely than immigrants to use food stamps (47% vs. 24%).

Table 7. Selected Characteristics of Year 3 Sample Mothers by Nativity[a]

Characteristic	All Mothers (*N* = 390)	Born in the U.S. (*n* = 167)	Foreign-born (*n* = 223)
TGA (%)**			
Glades	12	22	5
Non-Glades	78	66	87
Outside TGAs	10	12	9
Right Track initial risk screen (%)			
At risk/high need screen score	31	32	30
Study Risk Index***			
Mean (*SD*)	3.6 (*1.5*)	3.2 (*1.6*)	4.0 (*1.4*)
Range	0-8	0-8	1-8
Mother's race (%)**			
Hispanic	54	20	79
Black, not Hispanic	38	63	19
White, etc.	8	17	2
Age of mother***			
Mean age (*SD*)	27 *(5.7)*	24.6 *(4.7)*	28.5 *(5.8)*
Age range	17-46	17-42	18-46
Teen mother at child's birth (%)**	17	26	9
Mother's education (%)**			
High school/GED	22	32	14
Post HS education	23	31	17
Marital status (%)**			
Married, living with husband	30	17	40
Single, living with a partner	33	22	41
Single, in a relationship but not living with partner	10	20	3
Single, not in a relationship	26	40	16
Number of children (%)			
One	33	31	34
Two	34	36	33
Three or more	33	33	33
Employment (%)			
Mother currently working	49	55	45
Husband/partner working	89	82	93
Main language spoken in home (%)**			
English	45	90	12
Spanish	48	9	77
Other	7	1	11
Income-to-need ratio (%)			
Living at or below poverty threshold	54	52	55
Income support (%)**			
WIC	60	46	71
Food Stamps	34	47	24
Living conditions (%)			
Own home	24	29	20

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

**Denotes variable for which *z*-test of difference in proportions was statistically significant ($p \leq .05$).

***Denotes statistically significant differences in the study risk index means for native-born and foreign-born mothers ($F = 26.95$, $p < .001$).

Additional differences were observed when we considered the recency of immigration for the foreign-born mothers. A third of the mothers had lived in the United States for less than 5 years, and two-thirds for 5 years or longer. Compared with mothers who had lived in the United States for 5 years or longer, mothers who had immigrated more recently were more likely to be married or single and living with a partner (78% versus 86%), have just one child (26% versus 50%), speak Spanish at home (72% versus 89%), and be living at or below the poverty threshold (48% versus 72%). These results are presented in Table B-1 in Appendix B.

Mobility and Living Circumstances

As noted above, 10 percent of the study families had moved from the TGAs (primarily the non-Glades TGAs) to other areas of the county. In addition, a number of families moved within the TGAs. Altogether, 40 percent of the families moved at least once in year 2 and 42 percent moved in year 3. When mothers were asked in the year 2 and year 3 surveys how many different places they had lived during the past year, their responses ranged from one to six places. Most mothers who said they had moved did so just once in the previous year, though a small percentage (7% in year 2 and 6% in year 3) had moved more than once. When we compared mothers who reported moving at year 2, year 3, or both with those who did not, we found that 39 percent had stable housing and did not move either year, and 35 percent had moved only once in either year 2 or year 3. Of the remaining 26 percent of the sample, 14 percent had moved once in year 2 and once in year 3, and 12 percent had moved more than once each year.

In terms of other aspects of the living circumstances of the sample families, there was evidence of some improvement from year 2 to year 3. That is, the percentage of mothers reporting one or more negative housing conditions decreased from year 2 to year 3, as did the mean number of negative housing conditions. One factor may be the reduction in damage from hurricanes, which particularly impacted families in the second year of the study (see Table 8). Other indicators of the conditions of the sample families' living circumstances, which included neighborhood safety and ease of transportation, did not change significantly. With regard to safety, the percentage of mothers who felt their neighborhood was unsafe increased just slightly from 13 percent in year 1 to 16 percent in year 3. Although there was an increase in the percentage of mothers who reported that it was easy to get places from year 1 to year 2, the percentage (70%) was the same from year 2 to year 3.

As in previous years, almost a third of the sample mothers reported difficulty with transportation in the third year. However, there were some changes in the explanations given for their difficulties. As shown in Table 9, mothers continued to report the lack of a working car as the primary reason. However, they were less likely to report in year 3 that they could not drive or did not have someone to provide transportation than in previous years. They also were less likely to report that public transportation was not accessible in year 2 and year 3 compared with the first year—perhaps because they were more familiar with the transportation system and schedule or because of real improvements in the transportation system. In addition, they were less likely to report that their children made it hard for them to get places at year 3 than at year 2—perhaps because their children were getting older and more self-sufficient and, therefore, were easier to take places.

Table 8. Family Living Conditions at Year 1, Year 2, and Year 3[a]

Condition	Mothers at Year 1 (*N* = 390)	Mothers at Year 2 (*N* = 390)	Mothers at Year 3 (*N* = 390)
Residential Mobility (%)			
Did not move during past year	--[b]	60	58
Moved once during past year	--	33	36
Moved more than once during past year	--	7	6
Housing			
One or more negative housing conditions (%)*	**52**	**54**	**44**
Heat or air conditioning did not work	23	19	14
Broken windows or doors	14	19	11
Plumbing did not work	19	17	11
Cooking appliances did not work	20	13	11
Peeling paint	13	11	8
Electricity did not work	20	8	5
Overcrowded; not enough space	9	7	4
Not enough basic necessities for cooking, eating, or sleeping	10	7	5
Bare electric wires	4	3	1
Mean number of negative housing conditions (*SD*)*	1.4 (*1.8*)	1.2 (*1.6*)	0.9 (*1.2*)
Hurricane-related loss of $50 or more (%)*	**--**	**79**	**21**
Neighborhood (%)			
Unsafe neighborhood because of illegal activities	13	15	16
Transportation (%)			
Find it easy to get places*	57	70	70
Know how to drive	66	71	--
Have a driver's license	68	69	--
Have regular use of a car	78	82	--

[a] Data were weighted to adjust for the oversampling of Glades mothers and "at risk" mothers.
[b] In the baseline survey, mothers were asked how many different places they had lived in the last 2 years; two-thirds (66%) of the sample had moved at least once in the previous 2 years.
*Paired sample *t*-tests indicated that the following year-to-year differences were statistically significant at $p < .001$: One or more negative housing conditions2 vs. One or more negative housing conditions3; Hurricane loss2 vs. Hurricane loss3; and Easy to get places1 vs. Easy to get places2; Mean negative housing conditions1 vs. Mean negative housing conditions3; and Mean negative housing conditions2 vs. Mean negative housing conditions3.

Table 9. Reasons for Transportation Difficulties at Year 1, Year 2, and Year 3

Reasons[a]	% Mothers at Year 1 (*n* = 170)	% Mothers at Year 2 (*n* = 119)	% Mothers at Year 3 (*n* = 117)
Do not own or have access to a car (or car does not work)	72	78	74
Do not drive, no license, or no one to provide transportation	49	50	33
Public transportation not accessible or schedule is inconvenient	36	22	22
Children make it difficult to get places	--	15	8
Too expensive (e.g., do not have bus fare or gas money)	18	6	10
Other (e.g., physical limitations, don't know how to take bus)	19	6	5
Afraid to go out	--[b]	--	2

[a] Multiple responses allowed. Data were weighted to adjust for the oversampling of Glades mothers and "at risk" mothers.
[b] These items were not included in the year 1 or year 2 surveys.
*Paired sample *t*-tests indicated that the following year-to-year differences were statistically significant at $p < .01$ or less for changes between year 1 and year 2 and between year 2 and year 3: no car, don't drive, public transportation not accessible, and transportation too expensive; the decrease in the percentage of "other" reasons from year 1 to year 2 is also significant.

Summary

In the third year of the study, most of the study families still lived in one of the TGAs; 12 percent lived in the Glades TGA, and 78 percent lived in the non-Glades TGAs. Ten percent of the year 3 sample lived in other, nearby areas of Palm Beach County, which was a slight increase from the 6 percent who lived outside the TGAs in the previous year. Although this suggests some stability in the mothers who remained in the sample at year 3, we should also note that 42 percent of the families reported moving at least once during the year; this percentage is similar to the percentage of families who moved reported in year 2.

There was no change from year 2 to year 3 in the percentage of mothers who reported living in a home owned by a family member, which remained at 24 percent. Nor was there a change in the percentage of mothers (16%) who reported living in an unsafe neighborhood. On the other hand, there was one indication of improvement in living conditions reflected in a decline in the percentage of mothers who reported one or more negative housing conditions, such as electrical or plumbing problems, from year 2 (54%) to year 3 (44%). This result may be related, in part, to the fact that a much lower percentage of mothers (21%) reported experiencing financial losses because of hurricane damage than in the previous year (79%).

Overall, two-thirds of the mothers in the year 3 sample have worked at some point since the beginning of the study. Nearly half (49%) of them were working at the time of the year 3 interview, which was just slightly more than the 45 percent working in year 2. Mothers' estimates of their family income for the preceding year were very similar to those in year 2, with half (50%) of the sample reporting household incomes of less than $20,000 for the previous year. Calculation of an income-to-need ratio based on household size, the number of children under age 18, and the federal poverty thresholds indicated that 54 percent of the families in the year 3 sample were living at or below the federal poverty threshold the previous year.

Household sizes remained fairly constant during the first 3 years of the study. The percentage of mothers who reported they were married in the third year was the same as in the second year (30%), although the percentage of unmarried mothers who were living with a partner (33%) continued to decline from the first (40%) and second (37%) years. At the same time, there was an increase in the percentage of mothers with two or more children; two-thirds of the sample had two or more children at the time of the third interview. Almost one-quarter (24%) of the mothers had had another child since the birth of the focal child, and 8 percent were pregnant at the time of the year 3 interview.

HEALTH, HEALTH CARE, AND CHILD DEVELOPMENT

Mothers' Health and Health Care

When asked about the state of their health in year 3, a large majority (85%) of the mothers described it in favorable terms as "good," "very good," or "excellent." This percentage was significantly higher than the percentage of these mothers who described their health in similar terms the previous year (see Table 10). Consistent with the findings of the previous 2 years, the percentage of mothers who reported physical or mental health problems that kept them from working or attending school or limited the kind of work they could do was small (5%).

Mental Health and Functioning

Two instruments were again used to assess maternal functioning in the third year, the twenty-item Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) and the Parenting Stress Index Short Form (PSI/SF; Abidin, 1995). Table 10 shows that on both measures, a smaller percentage of mothers reported symptoms of both depression and parenting stress in year 3 than in previous years.

Scores on the CES-D can range from 0 to 60, with higher scores indicating the presence of more "depressive symptoms." The CES-D score for the sample in year 3 ranged from 0 to 52, with an average of 8.8. Nineteen percent had scores of 16 or higher, which is indicative of some depression, and 3 percent—just twelve mothers—had scores of 30 or higher, indicating the possibility of severe depression. (By comparison, in the previous year 24 percent had scores of 16 or higher, and 6 percent had scores of 30 or higher.) Compared with other mothers in the sample, the small group of mothers assessed with scores of 30 or higher on the CES-D in the third year were more likely to be native-born, to be single and never married, not to be in a relationship with a partner, and not to have had a pregnancy subsequent to the focal child. These mothers also had slightly higher levels of education, were somewhat more likely to be working, and demonstrated somewhat higher levels of parenting stress on the PSI/SF than the rest of the sample.

Scores on the PSI/SF can range from 0 to 180, with higher scores indicating greater stress; a score at or above the 85th percentile, defined as a raw score of 86 or higher, is considered indicative of clinically significant levels of stress. Total stress scores for mothers in the year 3 sample ranged from a low of 36 to a high of 170, with a mean score of 62.5. Eleven percent of the sample scored at or above the eighty-fifth percentile, which was a significant decrease from the 16 percent the previous year. Consistent with earlier findings, there was a significant correlation between the year 3 CES-D and PSI/SF scores ($r^2 = .412$, $p < .01$).

According to DCF administrative data, there were more investigations and indications of child abuse and neglect during the first 2 years after the birth of the focal child than in the third year (see Table 9).[21] Almost 10 percent of the mothers in the year 3 sample were investigated in

[21] It should be noted that DCF data are linked to children's names and demographics because we did not have enough identifiers to link them to mothers, so the data reported in this section pertain only to the focal child in the study. Thus, if a mother was reported for another child in the family, this information is not available.

the first year of their child's life, and 5.4 percent had indicated reports; almost 11 percent were investigated in the second year, and 7 percent had indicated reports. For comparison purposes, we also analyzed data on investigations and indicated reports for the TGAs and the county for 2004 to 2006. These data are presented in Appendix D. In comparing the indicated rates for the sample for the focal child's first and second years with the rates for the county and combined TGA population, it appears that the sample had a comparable rate to the county in the first year after birth (5.4% vs. 5.7%); this rate was lower than the rate for the TGA population in the first year (7.9%). In the second year, however, the rate for the sample (7.0%) was higher than the rates for both the county (4.1%) and the TGA population (5.8%).[22]

In all but a dozen cases, families who were investigated by DCF were reported in only one of the 3 years. During the 3-year period, there was a total of 101 investigations involving 85 respondents; 61 were investigated once, 11 twice (year 1 and year 2), and one, all 3 years. Thus, most children were investigated in either the first (n = 25) or second year (n = 30); six were investigated in the third year. Over the first 3 years, there were 61 indications of abuse/neglect involving 54 children/families (60% of the 101 investigated); 48 were indicated once, and three, twice. Most children were indicated in either the first (n = 22) or second year (n = 28); however, because we only have DCF data through the end of 2006, we do not have complete data on the percentage of mothers investigated for abuse or neglect in the third year.

Table 10. Mothers' Health and Maternal Functioning at Year 1, Year 2, and Year 3[a]

Characteristic	Year 1 (N = 390)	Year 2 (N = 390)	Year 3 (N = 390)
% Health "good/very good/excellent"[b]	83	78	85
Depression (CES-D)[c]			
% CES-D score ≥16	33	24	19
Mean (*SD*) Depression Score	12.8 (*10.10*)	10.3 (*8.92*)	8.8 (*9.06*)
Parental Stress (PSI/SF)[d]			
% PSI/SF score ≥ 86	--	16	11
Mean (*SD*) PSI/SF Score	--	64.8 (*22.02*)	62.5 (*19.39*)
% Use of alcohol (any)[e]	6	8	9
% Use of tobacco[f]	--	--	9
DCF report of abuse or neglect[g]			
% Investigated	9.7	10.6	--
% Indicated	5.4	7.0	--

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] A paired sample t-test indicates mothers' ratings of their health differed significantly from year 1 to year 2 and year 2 to year 3 ($p < .05$).
[c] A raw score of 16 or higher is above the normal range for the CES-D assessment. Paired sample t-tests indicate that mothers' mean depression scores decreased significantly from year 1 to year 2 ($p < .001$) and from year 2 to year 3 ($p < .05$).
[d] If a mother skipped two or more questions in any domain on the PSI/SF, her score was not included in the sample mean; these results are based on responses of 364 year 2 mothers and 374 year 3 mothers. The PSI/SF was not administered in year 1. A paired sample t-test indicates that mothers' mean stress score decreased significantly from year 2 to year 3 ($p < .05$)
[e] A paired sample t-test indicates that significantly more mothers reported use of alcohol in year 3 compared with year 1 ($p < .05$).
[f] Mothers were not asked about smoking in the first 2 years. According to Vital Statistics, 5 percent of the sample smoked or quit smoking during pregnancy.
[g] Source: DCF HomeSafenet ad hoc report for focal child only. Year 1 refers to the first year after the focal child's birth (0-1 year), and year 2, the second year (1-2 years). We do not yet have complete data for year 3 (2-3 years).

[22] Appendix D also discusses differences found within the TGAs: the rates for the Glades population were lower than the rates for the non-Glades population in both years.

Native-born mothers in the sample had a significantly higher percentage of investigations (17%) than foreign-born mothers (4%) in both the first year of their child's life ($\chi^2 = 22.76$, $p < .001$) and the second year (17% versus 6%) ($\chi^2 = 13.19$, $p < .001$). In terms of indicated reports, native-born mothers had a higher percentage (9%) than foreign-born mothers (3%) in just the first year ($\chi^2 = 8.59$, $p < .05$). There were no statistically significant differences in reports for the sample based on TGA of residence, although the 2004-2006 data for the TGA birth cohort suggest that victimization rates in the Glades are lower than they are in the other TGAs.

Alcohol and Tobacco Use

Just 9 percent of the mothers in the year 3 sample reported they currently drank alcoholic beverages. Although the percentage was small, it was a significant increase over the 6 percent reported by the same group of mothers in the year 1 interview. The average amount of alcohol consumed by these mothers also increased somewhat from the previous year, although only four mothers reported having four to six drinks per week. Forty-five percent of the mothers who drank alcohol said they had less than one drink per week compared with 67 percent the previous year; 44 percent reported drinking between one and three alcoholic drinks per week. With regard to smoking, 9 percent of the mothers in the year 3 sample said they smoked. (They were not asked about smoking in either of the year 1 or year 2 interviews, although Vital Statistics data indicated that only 5 percent of the mothers smoked.)[23]

Mothers' Health Care

The year 3 data showed just a slight decline in both the number of sample mothers who were covered by health insurance and the number who received regular medical care compared with the previous year (see Table 11). A little more than one-quarter (27%) of the sample did not receive regular medical care at the time of the year 3 interview.[24] Native-born mothers were more likely to receive regular care (82%) than foreign-born mothers (66%), a difference that can be attributed in part to lack of health insurance ($\chi^2 = 102.29$, $p < .001$). Only 15 percent of foreign-born mothers had health insurance in the third year compared with 71 percent of native-born mothers ($\chi^2 = 128.99$, $p < .001$)

The most frequent locations for routine medical care were public health clinics and doctors' offices. However, there were differences between native-born mothers and immigrant mothers in the primary location of their medical care. Among immigrants who reported getting regular care, more than half (61%) used a public health clinic, and about one-quarter (26%)

[23] These percentages may under-report actual use of alcohol and tobacco by study mothers. The percentage of sample mothers who reported drinking alcohol is much lower than the 2005 average of 51 percent reported for Florida or 50 percent nationally for all women 18 through 44 years of age (Department of Health and Human Services Centers for Disease Control and Prevention, 2005). In addition, the percentage obtained from Vital Statistics for mothers in the sample who smoked at the time of birth is much lower than the results of the 2006 Florida Adult Tobacco Survey indicating that 14 percent of women 18 years and older smoke.

[24] These results are despite the fact that almost a fourth (24%) had had a child subsequent to the focal child. Most of these mothers presumably would have been eligible to receive coverage through MomCare, a Medicaid-funded program authorized by the Sixth Omnibus Budget Reconciliation Act (SOBRA); however this coverage is limited to the first 60 days of the postpartum period.

received care at a doctor's office. In contrast, most (81%) of the native-born mothers who received regular care did so at a doctor's office, and just 13 percent at a public health clinic.

Table 11. Health Care of Mothers at Year 1, Year 2, and Year 3[a]

Characteristic	% Year 1 Mothers (*N* = 390)	% Year 2 Mothers (*N* = 390)	% Year 3 Mothers (*N* = 390)
Health Insurance			
Mother covered	56	41	39
Location of Mother's Routine Medical Care			
Doctor's office	44	39	38
Public health department clinic	38	32	28
Other clinic, health center, or emergency room	5	3	5
Mother does not get regular medical care	14	26	27

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

Paired sample *t*-tests indicate that a significantly higher proportion of mothers had insurance in year 1 than in year 2 or year 3 ($p < .001$) and a higher percentage of mothers did not receive regular medical care in year 2 or 3 than in year 1 ($p < .001$).

Women, unless they are pregnant, may not feel the need to see a physician on a regular basis for themselves—or, if they have a medical need, they may decide to postpone a visit to the doctor if they lack health insurance or have inadequate coverage. Tracy, a mother of two children who was interviewed in the qualitative study, put off needed surgery for her breast cysts because even with insurance from her job, she could not afford the $700 co-pay; she planned to discontinue the job-provided coverage and obtain Medicaid but knew there would be a period of time before the Medicaid coverage would begin. It was during this time that she learned she was pregnant with her second child and was told by her doctor that she could not have the surgery until after she delivered her baby.

Data from the qualitative study suggest that mothers are more concerned about making sure that their children receive health care than about their own health care. For example, Neena, an immigrant mother from Mexico with one child, told us that since her husband lost his job, they do not have insurance for themselves. However, she is not worried as long as they have Medicaid for their child: "No, now there is no insurance. But that is a lesser concern. Well, in our case, we practically don't get sick. Just as long as we have it for Enrique [child]." Tracy, described earlier, expressed a similar view:

> I have WIC, I have Food Stamps, Medicaid for the kids and myself. And that is all a huge, huge help because I can't afford insurance for the family. Once Medicaid expires for me I will be uninsured which is fine. I have been uninsured forever. It is just mostly the kids that I am worried about that they will always have insurance. The Food Stamps and the WIC helps a lot because all of our money goes to bills and rent.

Subsequent Pregnancies and Prenatal Care

A majority of the mothers who had given birth to another child since the baseline interview gave birth between the second and third interview; of the 24 percent who had given birth again, 4 percent gave birth between the first and second year.[25] Twenty-nine (8%) of the mothers were pregnant at the time of the year 3 interview; for four of these mothers, this was the second pregnancy since the birth of the focal child. Five percent of the mothers with a subsequent child said they had had a high-risk pregnancy. Two-thirds (68%) of these mothers reported receiving early prenatal care in the first trimester of their subsequent pregnancies; 24 percent said they started prenatal care in the second trimester; and 6 percent received late or no prenatal care. These self-reports on the initiation of prenatal care are almost identical to their reports of when they began prenatal care for the focal child.[26]

Children's Health and Health Care

Consistent with previous years, mothers' assessments of the health of the focal children were positive, with most (93%) describing the child's health as "good," "very good," or "excellent." One factor in mothers' ratings of their children's health was their special medical needs. Almost a fifth (18%) of the sample report that the focal child had special medical needs; the same proportion of mothers reported that other children in the family had special medical needs. A smaller percentage of mothers who said their children had special medical needs described the health of their children as "very good" or "excellent" (48%) than mothers whose children did not have special needs (79%) (χ^2=28.02, $p < .001$). In addition, almost a fifth (18%) of the sample also reported that other children in the family had special medical needs; there was little overlap between these mothers and mothers who reported that the focal child had special needs.

As shown in Table 12, the percentages of mothers reporting that a medical professional had told them that the focal child has special medical needs increased considerably from the first year to the second year, but remained the same in the third year. This suggests that some conditions in the focal children were not apparent or diagnosed at the time of the baseline interview. There also appeared to be some variability/instability in reports of special medical needs over time: almost a third (31%) of the mothers who reported that the focal child had special needs at the third interview had not reported them the previous year.

---

[25] These fertility statistics appear comparable to other reports. For example, a Center for Disease Control and Prevention report (2005) indicates that in 2002 the interval between first and second births was less than 12 months for 5 percent and between 13 and 24 months for 23 percent of low-income (defined as 0%-149% of poverty level) mothers ages 20-44.

[26] A subsequent analysis of Vital Statistics data on the birth of the focal child suggests that some mothers did not receive prenatal care as early as their self-reports suggested. The administrative data indicate that 99 percent of the sample received prenatal care, but only 40 percent were recorded as having received it in the first trimester, with 35 percent starting prenatal care in the second trimester. Twelve percent began prenatal care in the third trimester, and 12 percent were recorded as "unknown." Florida Department of Health Vital Statistics Annual Reports indicate that the percentage of all mothers initiating prenatal care in the first trimester in Palm Beach County was 73.6 percent in 2001, 78.7 percent in 2002, and 80 percent in 2003, but this fell to 72.3 percent in 2004 and 67.7 percent in 2005 (www.flpublichealth.com).

When asked to describe their child's specific needs, a handful of mothers reported specific permanent disabilities or conditions in their children, for example, sickle cell anemia, spina bifida, and De Morsier's syndrome. The most frequently reported medical condition for the focal children was asthma, which was mentioned by twenty-seven mothers—or more than a third (39%) of the mothers reporting that the focal child had special medical needs. Eleven mothers reported additional respiratory problems, including bronchitis. There was some variability by race/ethnicity in the frequency of different conditions. Within the small group of mothers who reported that their focal children had medical problems, mothers who were Black (55%) or mothers who were Hispanic (45%) reported a higher incidence of asthma and other respiratory conditions than mothers who were White or other races (11%).[27]

Table 12. Children's Health at Year 1, Year 2, and Year 3[a]

Characteristic	% Mothers at Year 1 (N = 390)	% Mothers at Year 2 (N = 390)	% Mothers at Year 3 (N = 390)
Focal Child's Health			
Child's health good/very good/excellent	91	88	93
Child has special medical needs	9	20	18
Other Children Have Special Medical Needs	18	17	18

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk." Paired sample t-tests indicate that the following differences are significant: mothers' assessments of their children's health in year 3 vs. year 2 ($p < .01$) and the percentage of target children with special needs in years 2 and 3 vs. year 1 ($p < .001$).

Children's Health Care

Nearly all mothers said their children receive regular medical care; most (90%) of the mothers reported taking their child to the doctor for at least one well-baby check-up in the 6 months prior to the third-year interview. On average, mothers said their child had been to the doctor three times in the past 6 months for routine care. Overall, by the time of the year 3 interview, mothers reported taking these children to the doctor an average of twelve times for routine care; the number of times varied from a low of four times to a high of fifty-one times.[28]

A large majority (84%) of mothers in year 3 reported taking their children to a doctor's office for routine medical care, whereas 13 percent took their children to a public health clinic and 2 percent to another clinic or health center. Over time, these results represent an increase in the use of a medical doctor and a decrease in the use of a public health clinic or another health center for children's care. As with their own care, the frequency with which immigrant and native-born mothers used a doctor's office versus a public health clinic for their children's health

[27] Of the entire year 3 sample of 390 mothers, these percentages correspond to 12 percent for Black mothers, 7 percent for Hispanic mothers, and 4 percent for other mothers. According to the National Center for Health Statistics (Akinbami, 2006), in 2004 and 2005, Puerto Rican (19%) and non-Hispanic Black children (13%) had higher rates of asthma than did non-Hispanic White children (8%).

[28] Mothers were asked every 6 months, both at the in-person annual interview and in the brief telephone interview, how many times they had taken the focal children to the doctor for "well-child" visits during the previous 6 months, or, in the case of the baseline interview, since birth.

care varied in the third year. Although a large majority of both groups were likely to use a doctor's office rather than a public health clinic, the percentage of native-born mothers who did so (89%) was significantly higher than the percentage of immigrant mothers (80%). Correspondingly, 18 percent of immigrant mothers used public health clinics for their children's care, whereas only 8 percent of native-born mothers did so (χ^2=13.80, $p < .01$).

Analysis of qualitative data also showed a decline in the use of public health clinics over time primarily because of the high cost of services for uninsured children and adults. The qualitative data suggest that mothers may start prenatal care at a public health clinic when they become pregnant and then continue to use it for a while after the birth of the target child, especially if they are also using the WIC program, which is usually located in the same facility as a public health clinic. Because of the expense, however, mothers use the clinic only sporadically for care for themselves, for children not eligible for public insurance, and for children who are eligible for coverage during lapses in Medicaid coverage—most often for family planning services, school physicals, and illnesses that cannot be treated at home.

As Gabriela, a 27-year-old mother from Ecuador, explained, the public clinics will provide care upfront and then ask for payment afterward: "Well, when I use the clinic, it is not that I don't pay, but I get into debt. I mean, they make me a bill and they say to me, 'pay what you can.' And so I am paying. But it is not that I have to bring the money with me so that they take care of me." Elvia, a 22-year-old mother from Mexico, described her experience similarly:

> Well, I was sick in my kidneys a while ago. When I got sick, I had to pay my doctor, to pay my medicines, to pay everything. Well, my husband, it was he who paid everything. There was no other option than to pay for it yourself. [Interviewer: And there are no clinics or anything that could help you?] No, because in the end, well, you end up paying. Even if you go to a clinic where they help you, they always say it is so much for the prescription, it is so much for the doctor and here, the prices are always very high.

Almost all of the mothers (93%) reported that the focal child had received all of his or her required immunization shots, and about three-fourths of these mothers had records of their shots. There were twenty-eight mothers (7%) who said their children had not received all of their shots. When asked why, twelve mothers said they did not have insurance to pay for the shots; six said the child had been sick at the time a shot was scheduled so it could not be given; five said they "had not gotten around to it" or "had not thought about it"; and five gave other reasons.

More than two-thirds (68%) of the mothers in the year 3 sample had health insurance for all of their children, and another 13 percent had coverage for some of their children (see Table 13). These percentages were lower than they were in the previous year.[29] Medicaid was the type of insurance reported most frequently for children, by 83 percent of the year 3 sample. Smaller percentages had coverage through an HMO (13%) or by the State Children's Health Insurance

[29] Various reports estimate that between 16 and 24 percent of Florida's children are uninsured and one-fourth of uninsured children do not receive any medical care during the year (Henry J. Kaiser Family Foundation, 2005).

Program (SCHIP) or Florida KidCare.[30]

Almost a third (32%) of mothers did not have insurance for some or all of their children, a 4-percent increase from the previous year. Given that more immigrant mothers than native-born mothers were without health insurance for some of their children, it is not surprising that the reason cited most often for lack of insurance for children was that the children were ineligible because they were not born in the United States (see Table 14).[31]

Table 13. Health Care of Children at Year 1, Year 2, and Year 3[a]

Characteristic	% Year 1 Mothers (*N* = 390)	% Year 2 Mothers (*N* = 390)	% Year 3 Mothers (*N* = 390)
Health insurance			
Focal child has insurance	**91**	**91**	**79**
All children in family covered	57	74	68
Some children in family covered	19	11	13
No children in family covered	25	16	20
Types of health insurance for children[b]			
Medicaid	65	75	83
Private plan or HMO	8	9	13
KidCare, SCHIP, MediKids, Healthy Kids, etc.	6	3	7
Location of children's routine medical care			
Doctor's office	59	79	84
Public health department clinic	34	18	13
Other clinic or health center	5	3	2
Children do not get regular care	2	0	1
Focal child received check-up in past 6 months[c]	--	98	90
Focal child has received recommended immunizations	--	--	93

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Percentages are based on the total sample of 390. Multiple responses were allowed.
[c] In the baseline interview, mothers were asked how many times they had taken their baby to the doctor since birth; whereas in subsequent interviews they were asked the number of times in the previous 6 months; therefore, year 1 responses are not included. All of the sample mothers took their newborn children to the doctor at least once during the first year.
Paired sample *t*-tests indicate that the percentages of children who had health insurance in year 2 and year 3 were significantly different from the percentage in year 1 ($p < .001$) as were the types of insurance; significantly more children were covered by Medicaid and by an HMO in year 3 than were in year 1 ($p < .001$).

Some of the children without health insurance were older children in the family who were born in another country. At the same time, 21 percent of the focal children—all of whom were born in the United States and presumably therefore eligible for Medicaid if below a certain income threshold—were without health insurance at the time of the year 3 interview. These were disproportionately children of immigrant mothers (73%) and families whose income-to-

[30] A recent policy brief by the Children's Services Council (February 2007) reported that participation in Florida's KidCare program declined statewide and in Palm Beach County between 2004 and 2006.
[31] To be eligible for Florida KidCare, children generally must be U.S. citizens. However, some non-citizen children who were classified by the federal government as "qualified aliens" are eligible, including children who have been legal permanent residents for at least five (5) years and Cuban and Haitian immigrants (www.floridadoh.com 4/22/08).

need ratio was somewhat more likely to be at or below the poverty level (60%). Almost half (49%) of these target children were children who were reported as not having insurance at either the year 1 interview or the year 2 interview, or both; just over half (51%) were without it at year 3 only.[32]

Table 14. Reasons Children Not Covered by Health Insurance at Year 1, Year 2, and Year 3[a]

Reason	Year 1 % Mothers (*n* = 170)	Year 2 % Mothers (*n* = 102)	Year 3 % Mothers (*n* = 126)
Program factors			
Paperwork is in progress	60	34	14
Child/family does not meet eligibility requirements			
-Not eligible because children not born in U.S.	--[b]	37	28
-Lost Medicaid or became ineligible for KidCare or MediKids (other reason not given)	8	20	22
-Not eligible – other reason[c] (divorced/widowed)	14	19	17
-Lost or changed job/changed or increased income	2	4	14
-Tried but did not qualify	1	5	5
-Insurance company refused coverage	2	4	13
Child on waiting list	5	7	2
Individual factors			
Cost too high	13	4	11
Coverage not offered by employer	12	3	4
Too much trouble	0	3	7
Did not know how to apply	11	2	0
Did not know was eligible	5	1	0
Other [c]	21	6	8

[a] Mothers who reported some or none of their children were covered. Multiple responses were allowed. Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] This response option was not included in the year 1 survey, but some mothers mentioned this as a reason in the category of "not eligible—other reason."
[c] "Other" includes "[Insurance] expired and has not renewed it", "[It] has to be done by computer and respondent does not have a computer", "respondent told to provide additional information", "respondent will apply tomorrow", "they keep sending letters, but not the cards", and "DCF took children away; father has custody".

The qualitative data help to clarify some of the reasons these mothers are without insurance for their children. Newborn children in families below a poverty threshold are eligible for Medicaid or the SCHIP program for 1 year after birth, and, according to mothers in the study, enrollment occurs at the hospital. However, there may be a waiting period before coverage is confirmed. For example, Maria, a 36-year-old mother from Cuba with three children, said it took time to get insurance coverage for her newborn twins:

> The babies were without insurance for like 2 months because they take at least a month. It's a month that they take to give you a response and then they tell you that the papers were not there or whatever and so you have to reapply and wait

[32] These percentages are weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

> another month for the response. [Interviewer: And you sent all the papers like it was supposed to be, but--] I put them, I put them here in a mailbox but it is not the first time that they get lost. I always have to make photocopies because I know they will possibly get lost.

In addition, to continue to receive health coverage for their children after their first birthday, mothers must recertify every year. Thus, there can be gaps in insurance while paperwork is being processed or if mothers do not reapply early enough before it expires. Below, 22-year-old Elvia describes the process for renewing her son's insurance as a time-consuming and difficult one for her:

> [Interviewer: So 6 months ago, you were using the clinic, the pediatrician, we talked about Medicaid, have you had any problems with Medicaid?] Yes (sighing), because he did not have it but then I went to apply. It took time [about 4 months], but they did give it to me ... In October is when they gave it to him. [Interviewer: You had to apply again? Every year you have to do an application?] Yes, each year an application … They did not want to take him, but I was returning the papers, putting everything correctly. Everything had to be right or they would not have taken him. So I went like four times. [Interviewer: By computer?] No. I took the papers because since I don't know the computer. But, well, the niece of my husband helped me to fill it out on the computer.

In contrast, Silvia, a 17-year-old mother from Guatemala, had a different experience with the reapplication process for Medicaid:

> It was almost easy because they gave it all to me in Spanish and they hardly asked me for much information. [Interviewer: They already had all of the information?] Yes. They only asked me for some. Just the change of address, that's it. [Interviewer: And you had to wait a lot?] For that it was approved about 15 days … It was fast.

As in previous years, mothers' lack of knowledge of public health insurance programs, their eligibility requirements, or the application process could be other reasons that children were uninsured in the third year. Among mothers who did not have coverage for some or all of their children, three-quarters (74%) said they had heard of KidCare, Florida's public health insurance program for children, the same percentage as in year 2. More than half (55%) were aware of the Healthy Kids program, an increase from 44 percent in year 2; and about half (49%) percent of mothers who had uninsured children knew about KidCare, the same percentage as in year 2. Smaller percentages of mothers were aware of Children's Medical Services (25%) and SCHIP (10%).

Health and Health Care by Selected Family Characteristics

Table 15 summarizes the status of the health and health care of mothers and their children in the third year by TGA community, race/ethnicity, and immigrant status. There were no significant differences in mothers' ratings of their health or their children's health as a function of TGA, although Glades mothers were somewhat more likely to report that their children had special

medical needs. However, there were differences according to race/ethnicity and nativity in health. Black and White/other mothers spoke more positively about their health and that of their children than Hispanic mothers but were somewhat more likely to report special medical needs. Similarly, native-born mothers were more positive about their health and that of their children than foreign-born mothers but more likely to report special medical needs. The reasons for these differences are not clear but may reflect differences in interpretations of the survey question about general health or different views of what it means to have special medical needs.

In addition, a higher percentage of mothers in the Glades TGA were insured and had some or all of their children covered by health insurance compared with non-Glades mothers and mothers outside the TGAs. Hispanic mothers were much less likely to have health insurance for themselves than mothers in the other racial/ethnic groups, although the percentage reporting coverage for some or all of their children was very close to those for other groups. Likewise, foreign-born mothers were significantly less likely to have insurance for themselves than mothers born in the United States.

Table 15. Mothers' and Children's Health Status by TGA, Race/Ethnicity, and Nativity at Year 3[a]

Indicator	% All Mothers (*N* =390)	TGA			Race/Ethnicity			Nativity	
		Glades (*n*=48)	Non-Glades (*n*=303)	Outside TGA (*n*=39)	Black (*n*=147)	Hispanic (*n*=212)	White/ Other (*n*=31)	Foreign (*n*=223)	U.S.-born (*n*=167)
Health Status									
Mother's health "good" to "excellent"	85	94	82	92	89	82	87	82	89
Mother has physical or mental health problem	5	4	6	5	7	4	13	3	8*
Focal child's health "good" to "excellent"	93	96	92	95	97	90	97	90	97*
Focal child has special medical needs	18	29	16	21	21	15	29	14	25**
Other children have medical problems	18	26	16	25	23	16	11	12	27**
Health Insurance									
Mother covered by insurance	39	71	35	26***	68	17	56***	15	71***
All/some children covered by insurance	80	92	79	77	85	78	77	75	87**
Focal child has insurance	79							72	85**
Health Care									
Mother receives regular medical care	73	94	71	58***	91	61	68***	66	82***
Child received well-child check-up in last 6 months	90	96	89	90	94	87	90	88	92

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
Chi-square tests indicated differences are statistically significant at *$p < .05$, ** $p < .01$. or *** $p < .001$.

Children's Behavior and Development

At the time of the third-year interview, the focal children ranged in age from 24 to 31 months, with an average age of 26 months. A majority (55%) of these children were boys.[33] In the third year, mothers were asked a small number of questions to indirectly assess the behavior and development of the focal children.[34] Drawn from the Early Childhood Longitudinal Study Birth Cohort (ECLS-B) 2-year parent interview (National Center for Education Statistics 2003; Andreassen & Fletcher, 2007), these items included the age at which their children first achieved the following developmental milestones appropriate for 2-year-old children:

- Child has started walking up stairs alone.
- Child has started saying words.
- Child has started turning the pages of a picture book, one at a time.
- Child has started opening a door by turning the knob and pulling.
- Child has started playing with other children and doing things with them.
- Child has starting using an object as if it were something else (e.g., using a block for a phone, using a cardboard box for a car or a doll bed, using a napkin for a doll blanket).

In addition, mothers were asked to describe their children's use of language and to indicate whether or not they had begun toilet training with their children.

Development is a function of both individual characteristics and the social environment. Although these behaviors and abilities serve as useful indicators about how a child is developing, the actual age at which a normally developing child exhibits them can vary considerably (Andreassen & Fletcher, 2007). Prior to the ECLS-B, there were no national norms available to link the age at which these milestones were achieved with future development, except for evidence suggesting that delays in reaching milestones are linked to poorer outcomes later.

Table 16 presents the percentages of sample children who had reached each milestone and the reported age at which children achieved each one. As the table indicates, a majority had reached all of the milestones by the time of the interview. Overall, the percentages and mean ages reported by mothers in the Palm Beach County (PBC) family study are comparable to those from the national ECLS-B sample with one exception. That is, a larger percentage of mothers in the PBC study (95%) than mothers in the ECLS-B study (80%) reported that their child had "started opening door by turning knob." This may reflect real differences in children's development or experiences but also could reflect differences in mothers' recall.[35]

---

[33] Five of the 390 mothers in the year 3 sample had multiple births, so in total, the year 3 sample represents 396 children, 178 girls and 218 boys. When responding to the child development questions, mothers of twins and triplets were asked to refer to the oldest child. There were no differences in the mean ages of boys and girls. Both had a mean age of 26.3 months, with a standard deviation of 1.7 for boys and 1.5 for girls.

[34] Another potential source of developmental information on these children are scores on the Ages and Stages Questionnaire (ASQ), which is filled out by parents who receive some maternal health services or whose children are enrolled in childcare. However, completion rates tend to be low; ASQ data were available for just 11 percent of the sample children in the third year. We hope to have more complete ASQ data next year.

[35] It also should be noted that the average age of the children in the PBC study at the time this information was reported by mothers was slightly older (26 months) than the average age of children in the ECLS-B study (24 months).

Table 16. Percentage of Focal Children Reaching Developmental Milestones at Year 3 Interview

Developmental indicator	PBC Family Study Sample (N = 390)		ECLS-B National Sample ($N \approx$ 9,800)	
	% Reached Milestone[a]	Mean Age[b] (*SD*)	% Reached Milestone[c]	Mean Age[b] (*SD*)
Started walking upstairs alone	91.3	14.4 (*4.30*)	93.9	15.4 (*3.75*)
Started saying first words	99.7	11.5 (*4.59*)	99.5	11.1 (*3.86*)
Started turning pages of book one at a time	96.9	15.5 (*5.01*)	96.0	13.7 (*4.12*)
Started opening door by turning knob	95.1	17.2 (*5.25*)	80.2	18.4 (*3.94*)
Started playing with other children	98.4	14.2 (*4.94*)	96.8	13.6 (*4.53*)
Started pretending in play (e.g., using an object for something else)	95.8	16.4 (*4.76*)	94.3	15.3 (*4.15*)
Demonstrated all six milestones at year 3 interview	77.9			

[a] Percent of mothers reporting at time of year 3 interview when focal child reached milestone.
[b] Mean age reported by mother when child reached milestone for children who reached milestone.
[c] Percent of mothers reporting child demonstrated behavior at 23-25 months in national ECLS-B sample (Andreassan & Fletcher, 2007).

Toilet Training

Another important milestone for parents of 2-year-olds is toilet training. According to the American Academy of Pediatrics (www.aap.org), there is no set time to begin toilet training. Most parents start teaching their child to use the toilet between 2 and 3 years of age, with some evidence of variations as a function of family income and race/ethnicity (Horn et al., 2006). Consistent with the age of the focal child at the time of the third interview, a majority (72%) of the mothers in the sample reported that they were working on toilet training with this child; 17 percent said their child could use the toilet independently, and 11 percent of the mothers said that they had not yet started toilet training with their child. A larger percentage of girls were reported to be toilet trained than boys. Overall, development in this area appears to be progressing normally.

Table 17. Stage of Toilet Training at Year 3[a]

Toilet Training Stage	% All Children (N = 390)	Sex of Child		Age of Child (Months)	
		% Boys (n = 216)	% Girls (n = 174)	Mean (*SD*)	Range
Parent has not started toilet training child	11	12	9	25.9 (1.20)	24-30
Parent is working on toilet training child	72	78	65	26.2 (1.57)	24-35
Child can use the toilet independently	17	10	26	27.1 (1.94)	24-33

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk." Chi-square test indicated difference between boys and girls is statistically significant ($\chi^2 = 16.77$, $p < .001$).

Language Development

Children develop language skills largely through social interactions—playing, listening, talking, and reading with other people—and children learn the style and rules of communication that are characteristics of their family and culture. As with other areas of development, children learn language at very different rates depending on both individual characteristics and the social context. However, most have said their first words by their first birthday, and most have started combining words by their second birthday. Children's early language and communication skills are important in their own right, but they are also closely linked to their cognitive and social development and, particularly, their future language and literacy development. Thus, we believe it is particularly important in the PBC family study to attempt to assess children's language development during the preschool years.

As indicated in Table 16, nearly all of the focal children were talking, having uttered their first words between 11 and 12 months of age. All but 4 percent of the mothers reported that the focal children were combining words at the time of the third interview (see Table 18). By comparison, 16 percent of the national ECLS-B sample reported that their children had not yet started combining words at a similar age. About half (51%) of the mothers reported that their children typically talk in two- or three-word phrases, and a fourth (26%) said their children were talking in complete sentences. By comparison, a somewhat larger percentage (31%) of mothers in the ECLS-B reported that their children were talking in complete sentences. Consistent with most research on early language development, girls in the study families were more likely than boys to be combining words frequently and talking in sentences.

Table 18. Children's Language and Communication Skills at Year 3[a]

Language Characteristic	% All Children (*N* = 390)	Sex of Child	
		% Boys (*n* = 216)	% Girls (*n* = 174)
How frequently child combines words^			
Has not done this yet	4	6	2
Once to several times a week	4	5	2
Once a day	2	2	2
Several times a day	90	88	94
How child communicates* **			
Child does not talk yet	1	2	0
Mostly talking in one-word sentences	23	28	16
Talking in 2- to 3-word phrases	51	52	49
Talking in fairly complete, short sentences	23	17	31
Talking in long and complicated sentences	3	1	4

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
Chi-square tests indicate that girls tended to combine words with more frequency than boys (p =.10) and are significantly more likely to use complete sentences than boys ($p < .001$).

The topic of children's developing language was a frequent one in the third wave of qualitative interviews, which were conducted around the focal child's second birthday. Mothers seemed eager to share stories of their children's new accomplishments, conveying excitement

and pride about their children's increasing independence and physical skills, but particularly about their growing ability to comprehend language and verbally communicate their needs and wants. An example is the following passage from Norma, a 22-year-old mother of a 28-month-old, who is pleased not only with her child's progress in toileting training but also his ability to let her know when he needs to use the toilet:

> And he's talking a lot more now. It's like, "oh my god! Ohhh, it begins!" Now he's saying more than two words, and you can understand what he's saying. It's like, "Wanna go outside," or "Mommy, I wanna pee-pee." I have to run to the bathroom, take his pamper off. So after I do that, I put him in a little underwear, and he'll be in underwear all day, the rest of the day. So, I'm really excited about that. I am so happy that he's actually telling me he wants to [go]. I don't know if that's what they're doing at the daycare, but I am so happy.

Marta, a 23-year-old mother of two children, told us that she mostly speaks Spanish to her 2-year-old son, although she spoke English with her older, 8-year-old daughter when she was learning to talk. In the excerpt from her interview below, she expresses surprise and amusement about the fact that her son responds to her in English. She attributes his behavior to television (although it could also be the influence of his older sister).

> With [his sister], I used to speak to her in English when she was little. And mostly my parents [spoke Spanish to her]. Now, with him, I talk to him in Spanish, and even my husband, everybody. Luisa speaks to him in English 'cause, you know, that's her primary language. But my mom speaks Spanish, everybody speaks Spanish. [But], guess [what] … I would ask him something or talk to him [in Spanish], and he will answer me back in English. I'm like, "How do you know that? Where do you get it from." "T.V." … He says, "Oh, my god!" You say something, and he goes, "Oh, my god!" He's so funny.

Although most mothers were positive about their children's development, a few expressed concern about their progress. In the excerpt below, Holly, an 18-year-old mother of two young children, questions her child's lack of language development, based on her observations of other children and, perhaps, her own frustration in communicating with him:

> He says a [few] words, [but] he don't say [anything]. He's like "Eat, eat. Juice, juice." And we're trying to get him to say "thank you." He only says it when he wants to, you know what I mean? … And when he wants something, when he's really trying to get you to understand, he'll say "juice," you know; he wants something to drink. "Eat, eat," you know, he wants to eat. But besides that, he should be doing more than that.

Holly goes on and tries to reassure herself that every child develops differently but then voices her desire for her child to do more:

> But at the same time, it's okay; everybody's different. All kids, they aren't going to be perfect. They have their ways. He just likes the stuff that he does. [But] I see other kids…[and] he should be doing more … communication. I wish he could communicate

more, then maybe he wouldn't get so frustrated. That's why he gets frustrated. You know, he can't talk so he'll get me and drag me somewhere to what he's trying to tell me. Now I have to sit there and figure out, "You want this? You want that?" He don't even call me mom, be like, Mom. Mom. You know. And I would like for him to do that.

Summary

Indicators of maternal functioning included mothers' self-reported health, a measure of depression, a measure of parental stress, and administrative data on reports of child abuse and neglect. The first three indicators showed improvements from the previous years. Most (85%) of the mothers described themselves as in "good" to "excellent" physical health in year 3 compared with 78 percent in year 2. Smaller percentages of mothers than in previous years had above-normal scores on the CES-D depression scale (19%) and the PSI/SF measure of parenting stress (11%). In terms of the percentage of mothers with reports of abuse or neglect in the DCF database, however, there was a small increase from year 1 to year 2. Almost 10 percent of the mothers in the year 3 sample were investigated in the first year of their child's life, and 5.4 percent had indicated reports; almost 11 percent were investigated in the second year, and 7 percent had indicated reports.

Access to health care is another indicator of maternal health. A majority (73%) of the mothers reported receiving regular medical care for themselves at the time of the year 3 interview, but this still indicates that, as in year 2, more than a quarter of the sample mothers were going without routine health care. This group of mothers, therefore, is less likely to have access to services that will keep them healthy in between pregnancies and healthier should they become pregnant again. In that regard, use of prenatal care by mothers who had given birth to a child subsequent to the focal child followed the same pattern observed with the focal child. That is, among the 24 percent of the mothers who had had a subsequent pregnancy, about two-thirds (68%) said they had initiated care in the first trimester, 24 percent in the second trimester, and 6 percent in the third trimester.

More than three-fourths (79%) of the focal children were covered by health insurance in the year 3. The fact that 21 percent of the focal children, as well as other children in the study families, were not covered is a concern, however. An addition concern is the fact that only 39 percent of the sample reported having health insurance for themselves, which is a slight decline from year 2. In terms of both health care and health insurance, there were marked differences between immigrant and native-born mothers. Native-born mothers were more likely to receive regular care (82%) than foreign-born mothers (66%), and only 15 percent of foreign-born mothers had health insurance in the third year compared with 71 percent of native-born mothers.

The results for children's health and health care were somewhat more encouraging. Most mothers reported the focal child to be in "good" to "excellent" physical health, although 18 percent of the mothers reported that the focal child had "special needs," with asthma and other respiratory problems being the dominant types of special needs. In addition, based on mothers' reports on a small number of measures used in the national ECLS-B longitudinal study of children's physical, cognitive, social, and language development, most of the children were developing within ranges comparable to the national sample.

PARENTING PRACTICES AND BELIEFS

Child development is shaped by a variety of factors. In the early years, children are particularly influenced by their home environments and interactions with parents and other family members. Thus, in the effort to understand the effects of the Palm Beach County service system on children's development, it is important to gather information about other influences, including home and neighborhood characteristics, children's daily activities, and the kinds of parenting practices they experience. In this section, we describe the kinds of parenting activities that study mothers reported for themselves and their husbands or partners in the third-year interview. We clustered these activities into two broad categories, "positive" and "negative," to reflect their potential for either beneficial or harmful effects on development. We also use data from qualitative interviews about mothers' daily caregiving routines, their play and learning activities with their children, and their aspirations for their children to supplement and elaborate the survey data. As mothers talked about these topics, they also revealed the values and beliefs that underlie their parenting practices.

Positive Parenting Practices

A sizeable majority of the mothers reported in the survey that they and their husbands or partners engaged in a variety of positive parenting practices during the previous 3 months. As shown in Table 19, more than three-quarters of the mothers reported that they engaged in the following activities with their children: took their child on errands, praised their child, took their child

Table 19. Year 3 Positive Parenting Activities during Previous 3 Months[a]

Activity	% Mothers (*N* = 390)	% Husbands/Partners (*n* = 281)	Mean Frequency[b] (*SD*)
Praised child	99	97	**2.8** ***(.40)***
Took child on errands (e.g., post office, bank, or store)	99	88	**2.3** ***(.53)***
Took child outside for walk or play	96	89	**2.1** ***(.65)***
Sang songs with child	93	79	**2.5** ***(.62)***
Read books to child	93	81	**2.2** ***(.69)***
Encouraged child to read a book	88	72	**2.4** ***(.65)***
Told stories to child	87	64	**2.1** ***(.70)***
Played with clay, drew pictures, or did other arts and crafts	76	51	**1.9** ***(.66)***
Played with a game, puzzle, or building toy with child	72	56	**2.0** ***(.70)***
Did household chores with child	71	38	**2.2** ***(.79)***
Talked to children about a television program	71	54	**2.1** ***(.79)***
Took child to library	28	13	**1.3** ***(.52)***
Mean *(SD)* Positive Parenting Score (range: 0-1)[c]	.91 (*.13*)	.78 (*.23*)	

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Average frequency reported by only those mothers who responded affirmatively that either they or their partner/husbands had done each activity during the previous 3 months, using a 3-point scale: 1 = "once or twice a month," 2 = "at least once a week," and 3 = "daily or most days."

[c] The mean parenting score is based on only the items included in all surveys so that comparisons could be made over time. The following items were excluded in calculation of the mean: "played with a game, puzzle, or building toy," "did household chores," "talked about a television program," and "took child to library."

outside to play, sang songs with their child, read books to their child, encouraged their child to read a book, and did arts and crafts with their child. However, a much lower percentage (28%) of mothers took their child to the library during the previous 3 months.

In families in which husbands or partners had had contact with their children during the previous 3 months, the distribution of their parenting activities was similar to that of mothers, although the percentage of fathers who engaged in each activity tended to be lower than that of mothers. Mothers reported that their husbands or partners most often had engaged in the following activities: praised their children, took them on errands, took their children outside to play, sang songs with their children, and encouraged them to read a book. When asked about the frequency of various activities, mothers reported that they or their husbands/partners tended to engage in all of the parenting activities, on average, about once per week, with the exception of taking their children to the library, which was done much less frequently.

> *The typical day—we get [the children] out of bed around 8:30 a.m. We bring them downstairs. We just play a lot; we read to them, we give them breakfast.*
>
> ~Miriam, 26, mother of three

Reading to children is considered an especially important parenting activity for fostering children's language and literacy development and school readiness (e.g., Beals, Temple, & Dickinson, 1994; Raikes, Luze et al., 2006; Snow, Burns, & Griffin, 1998). As Table 19 indicates, nearly all (93%) of the sample mothers said they had read books to their children during the previous 3 months; and a large majority (81%) reported that their partners had done so as well. At the same time, only about a third (34%) of the mothers reported that they or their partners read to their children "daily or most days."

By comparison, these percentages are somewhat lower than those indicated in a recent report of the Early Head Start Research and Evaluation Project, which stated that about half of a sample of 2,500 low-income mothers said they read to their 1- to 3-year-old children daily (Raikes et al., 2006b). These differences may be associated with differences in sample characteristics: for example, the sample in the PBC Family Study has a higher proportion of immigrant and Spanish-speaking mothers and a higher proportion of mothers who had not completed high school than the Early Head Start sample.

In the PBC sample, immigrant mothers (27%) were significantly less likely to report reading to their children on a daily basis than mothers who were native-born (42%) ($\chi^2 = 9.46$, $p < .01$) Correspondingly, Spanish-speaking mothers (19%) were significantly less likely to report reading to their children "daily or most days" than English-speaking mothers (44%) or Haitian Creole-speakers (56%) ($\chi^2 = 31.08$, $p < .001$); and mothers with less than a high school education (26%) were less likely to read to their children on a regular basis ("daily or most days") than mothers who were high school graduates (42%) ($\chi^2 = 11.86$, $p < .01$). With regard to these selected variables, it is important to note that they are likely to be correlated with one another. Interactions and relationships among these and other variables will be explored later in this report.

Positive Parenting Activities over Time

Mothers' reports in the first 3 years of their own and their husband's or partner's positive parenting practices are summarized in Tables 20 and 21. The mean number of positive parenting practices that mothers reported that they and their husband or partner used was significantly higher in year 2 than in year 1, a change that may reflect the fact that their children were older.

Table 20. Mothers' Positive Parenting Activities over Time[a]

Activity	% Mothers at Year 1 (*N* = 390)	% Mothers at Year 2 (*N* = 390)	% Mothers at Year 3 (*N* = 390)
Praised child	95	99	99
Took child on errands (e.g., post office, bank, or store)	90	99	99
Took child outside for walk or play*	77	96	96
Sang songs with child*	87	95	93
Read books to child*	72	93	93
Encouraged child to read a book[b]	95	91	88
Told stories to child*	64	84	87
Played with clay, drew pictures, or did other arts and crafts*	34	70	76
Played with a game, puzzle, or building toy with child (Y2)	—	76	72
Did household chores with child (Y2)	—	68	71
Talked to children about a television program (Y3)	—	—	71
Took child to library (Y2)	—	27	28
Mean *(SD)* Positive Parenting Score (range: 0-1)[c]*	**.75 (*.22*)**	**.91 (*.13*)**	**.91 (*.13*)**

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Asked only of mothers with children 1 year or older (n = 199 in year 1 and n = 382 in year 2).
[c] Mean parenting scores are based on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3 that were excluded in the calculation of mean scores.
*Paired sample t-tests indicate that differences between the following year 1 and year 2 and year 1 and year 3 measures were statistically significant at $p < .05$ or less: took on errands, took outside, sang songs, read books, told stories, did arts activities, praised, and the mean positive parenting score.

In terms of specific kinds of activities reported more frequently by mothers over time, most differences occurred between the first and second year. The only noteworthy difference between year 2 and year 3 was an increase in the percentage of mothers who reported engaging in art activities, such as playing with clay and drawing pictures, which, again, is consistent with the increasing age of their children. Similarly, there was a general increase from year 1 to year 3 in reported activities of fathers or partners, with virtually no difference between years 2 and 3. The only noteworthy difference between year 2 and year 3 was a decline in the percentage of fathers reported to encourage their child to read a book.

Table 21. Fathers' Positive Parenting Activities over Time[a]

Activity	% Father/Partner at Year 1 (*N* = 312)	% Father/Partner at Year 2 (*N* = 302)	% Father/Partner at Year 3 (*N* = 281)
Praised child	90	95	97
Took child outside for walk or play*	69	90	89
Took child on errands (e.g., post office, bank, or store)*	76	90	88
Read books to child*	50	75	81
Sang songs with child*	69	81	79
Encouraged child to read a book*	85[b]	80	72
Told stories to child*	52	68	64
Played with a game, puzzle, or building toy with child (Y2)*	—	65	56
Talked to children about a television program (Y3)	—	—	54
Played with clay, drew pictures, or did other arts and crafts*	29	54	51
Did household chores with child (Y2)	—	43	38
Took child to library (Y2)	—	16	13
Mean *(SD)* Positive Parenting Score (range: 0-1)	**.63 (*.29*)**	**.79 (*.22*)**	**.78 (*.23*)**

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Asked only of mothers with children 1 year or older (n = 172 in year 1 and n = 296 in year 2).
[c] Mean parenting scores are based on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3 that were excluded in the calculation of mean scores.
* Paired sample t-tests indicate that differences between the following year 1 and year 2 and year 1 and year 3 measures were statistically significant at $p < .05$ or less: praised, took outside, took on errands, read books, sang songs, told stories, did arts activities, and the mean positive parenting score. Also significant were the differences between the year 2 and year 3 "encouraged reading" and "played a game" items.

Negative Parenting Practices

There is also considerable literature to suggest that maternal depression and harsh parenting can have harmful effects on children's social and emotional development (e.g., Bradley & Corwyn, 2007; Chang et al., 2004).[36] Thus, we also asked mothers about their disciplinary and other so-called negative parenting practices during the previous 3 months. Just over half (53%) of mothers reported that they had lost their temper with their child; almost a third (31%) said they had found hitting or spanking their child was a good way to get the child to listen; and less than a fourth (22%) said they got angrier with their child than they had intended during the previous 3 months. Smaller percentages said that in the past 3 months they had punished their child for not finishing the food on their plate (6%) or blamed their child for something that was not the child's fault (10%).

Mothers whose husbands or partners had had contact with their children in the previous 3 months reported somewhat lower percentages of negative parenting practices for their husband or partner than they reported for themselves (see Table 22). When asked about the frequency

[36] It is also important to note that the literature on parenting suggests that the relationships between positive and negative parenting and children's outcomes are complex and mediated by a number of factors, including children's own personalities and temperament and the other contexts, e.g., school, in which they grow.

with which they or their husbands or partners engaged in any of these activities, mothers reported that each practice occurred, on average, between once or twice a month and once a week.

Table 22. Year 3 Negative Parenting Activities during Previous 3 Months[a]

Activity	% Mothers (*N* = 390)	% Husbands/Partners (*n* = 281)	Mean Frequency[b] (*SD*)
Lost temper with child	53	48	**1.7** ***(.64)***
Found hitting/spanking a good way to get child to listen	31	26	**1.4** ***(.56)***
Got more angry than meant to with child	22	12	**1.5** ***(.65)***
Blamed child for something not child's fault	10	7	**1.2** ***(.40)***
Punished child for not finishing food on plate	6	6	**1.6** ***(.77)***
Mean *(SD)* Negative Parenting Score (range: 0-1)[c]	.17 *(.21)*	.13 *(.19)*	

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Average frequency reported by only those mothers who responded affirmatively that either they or their partner/husband had done each activity during the previous 3 months, using a 3-point scale: 1 = "once or twice a month," 2 = "at least once a week," and 3 = "daily or most days."
[c] The mean parenting score is based on only the items included in all surveys so that comparisons could be made over time. The item "lost temper with child" was excluded in calculation of the mean.

Negative Parenting Activities over Time

Although we found an increase in some of parents' positive parenting activities between year 1 and year 2, there was no significant change between mothers' overall reports of their or their husband/partner's use of negative parenting practices over time, as expressed in the mean negative parenting scores (see Tables 23 and 24). However, we did observe changes over time in selected practices. Notably, there was a decline between year 1 and year 2 reports of getting more angry than intended with a child and punishing a child for not finishing food. On the other hand, there was an increase between year 1 and year 2 reports of hitting or spanking children. These trends were noted in mothers' reports for both themselves and their husbands or partners.

Table 23. Mothers' Negative Parenting Activities over Time[a]

Activity	% Mothers at Year 1 (*N* = 390)	% Mothers at Year 2 (*N* = 390)	% Mothers at Year 3 (*N* = 390)
Lost temper with child (Y2)	—	53	53
Found hitting/spanking a good way to get child to listen*	21	29	31
Got more angry than meant to with child*	27	21	22
Punished child for not finishing food on plate*	16[b]	6	6
Blamed child for something not child's fault	21[b]	13	10
Mean *(SD)* Negative Parenting Score (range: 0-1)[c]	**.18** ***(.26)***	**.17** ***(.23)***	**.17** ***(.21)***

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Asked only of mothers with children 1 year or older (*n* = 199 in year 1 and *n* = 382 in year 2).
[c] Mean parenting scores are based on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3 that were excluded in the calculation of mean scores.
*Paired sample *t*-tests indicate that differences between the following year 1 and year 2 and year 1 and year 3 activities were statistically significant at $p < .05$ or less: hit/spanked and punished for not finishing food; the difference between got angry at year 1 versus year 2 was also significant.

Table 24. Fathers' Negative Parenting Activities over Time[a]

Activity	% Father/Partner at Year 1 (*N* = 312)	% Father/Partner at Year 2 (*N* = 302)	% Father/Partner at Year 3 (*N* = 281)
Lost temper with child (Y2)	—	41	48
Found hitting/spanking a good way to get child to listen*	18	24	26
Got more angry than meant to with child*	19	12	12
Punished child for not finishing food on plate*	14[b]	5[a]	6
Blamed child for something not child's fault	16[b]	9[a]	7
Mean *(SD)* Negative Parenting Score (range: 0-1)[c]	**.14 *(.24)***	**.12 *(.21)***	**.13 *(.19)***

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Asked only of mothers with children 1 year or older (*n* = 172 in year 1 and *n* = 296 in year 2).

[c] Mean parenting scores are based on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3 that were excluded in the calculation of mean scores.

* Paired sample *t*-tests indicate that differences between the year 1 and year 2 and year 1 and year 3 "got angry" item were statistically significant at $p < .05$ or less; also significant were the differences between year 1 and year 3 "hit/spanked" and "punished for not finishing food."

Parent Involvement Activities

Another important area of parenting is involvement in children's childcare and education. Research has shown the value of parent involvement in both early childhood education and later schooling with respect to children's academic outcomes (e.g., Epstein, 2001; Hill & Craft, 2003; Jeynes, 2003; Meidel & Reynolds, 1999). At the time of the year 3 interview, three-fourths of the mothers had children who were in childcare or school and, thus, were asked additional questions about their involvement in their children's out-of-home care and education. As shown in Table 25, more than two-thirds (69%) of these mothers reported talking with their children's teacher during the previous 3 months. About half of the mothers had attended a parent-teacher conference (52%), and about half had helped their child with homework (50%). More than one-third reported they had participated in a field trip or school event for families (38%) or attended a PTA meeting (38%) during the past 3 months. Except for helping with homework, the percentage of fathers who engaged in any of these activities was smaller than the percentage of mothers.[37]

In terms of changes in parent involvement activities over time, there was a general decline between year 1 and year 2 and virtually no change between year 2 and year 3. The reason for the initial decline is not clear, given the fact that children in the sample families were older. It may be that other family members are assuming some of these responsibilities or that mothers who were working in year 2 or year 3 have less time to participate in these activities, or both. For example, Table 24 shows a small increase in the percentage of fathers attending parent-teacher conferences.

[37] It should be mentioned that the types of activities in Tables 24 to 26, except for helping with homework, differ from other parenting activities in that they are unlikely to occur as regularly.

Table 25. Year 3 Parent Involvement Activities during Previous 3 Months [a,b]

Activity	% Mothers (*N* = 291)	% Husbands/Partners (*N* = 196)
Talked to teacher about child's progress (at times other than parent-teacher conference)	69	35
Helped child with homework	50	49
Attended parent-teacher conference	52	32
Attended PTA meetings	35	18
Participated in field trip or family event at school	38	24
Mean *(SD)* Parent Involvement Score (range: 0-1)	**.48 *(.37)***	**.32 (*.33*)**

[a] Only mothers who had children in childcare or school were asked about these activities.
[b] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

Table 26. Mothers' Parent Involvement Activities over Time[a]

Activity	% Mothers at Year 1 (*N* = 167)	% Mothers at Year 2 (*N* = 256)	% Mothers at Year 3 (*N* = 291)
Helped child with homework	74	49	50
Attended parent-teacher conference	66	50	52
Talked to teacher about child's progress (at other times)	—	—	69
Participated in field trip or family event	—	35	37
Attended PTA meetings	—	38	34
Mean *(SD)* Parent Involvement Score (range: 0-1)[b]	**.70 (*.40*)**	**.43 (*.41*)**	**.48 (*.37*)**

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Mean parent involvement score based on all items asked at each time point.

Table 27. Fathers' Parent Involvement Activities over Time[a]

Activity	% Father/Partner at Year 1 (*N* = 127)	% Father/Partner at Year 2 (*N* = 184)	% Father/Partner at Year 3 (*N* = 196)
Helped child with homework	65	48	49
Attended parent-teacher conference	38	26	32
Talked to teacher about child's progress (at other times)	—	—	35
Participated in field trip or family event	—	22	24
Attended PTA meetings	—	26	18
Mean *(SD)* Parent Involvement Score (range: 0-1)[b]	**.51 (*.39*)**	**.31 (*.36*)**	**.32 (*.33*)**

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Mean parent involvement score based on all items asked at each time point.
* Paired sample *t*-tests indicated that the difference between fathers' attendance at PTA meetings at year 2 and year 3 was statistically significant at $p < .01$.

Correlates of Parenting Activities

To explore the relationships between family characteristics and parenting practices, we examined several bivariate associations between mothers' parenting practices and a range of family characteristics, including maternal age, education, employment, income, nativity, and involvement of husband or partner. Again, it should be emphasized that these results do not imply causation at this point; many of the variables examined may be related to one another, and complex interactions and relationships among the variables will be explored later. However, we present them as suggestive of the kinds of factors that may impact parenting practices and the kinds of relationships that may exist between parenting practices and children's development.

Among the family characteristics we examined, there was no striking difference as a function of family income or maternal age in reported use of positive parenting activities. However, as shown in Tables 28 and 29, the frequency of particular positive and negative parenting activities differed significantly by three other characteristics of mothers that are highly correlated in this sample—educational background, race/ethnicity, and immigrant status. These included learning activities such as reading books, telling stories, singing songs, playing games, drawing or other art activities, and going to the library. For example, Hispanic mothers reported lower rates of these activities than mothers in other racial/ethnic groups; mothers who had not graduated from high school also reported lower rates than mothers who had completed high school. Both of these groups also differed from other mothers in terms of their disciplinary or negative parenting practices, for example, using hitting or spanking to get a child to listen.

Other significant associations suggest that maternal employment, marital status, and cohabitation may also influence mothers' parenting practices. There was a trend for mothers who were not working to report more positive parenting practices, resulting in a significant difference between the mean positive parenting score for these two groups. In addition, mothers who were married were more likely to report use of positive parenting practices and less likely to report use of negative parenting practices than mothers who were single but living with a partner. This finding is consistent with other studies that indicate that mothers married to fathers are at lower risk for negative parenting (Guterman & Lee, 2006). It may be that conflicts over child-rearing practices between unmarried partners inhibit positive parenting practices or that parents' conflicts over other matters take time away from positive activities with children. For example, in explaining why she planned to separate from her partner, Miriam, a single mother of three children, said "We just don't see eye-to-eye on how we're supposed to raise the kids and how life is supposed to be for us. I refuse to compromise a little his way; he refuses to compromise my way." She went on to say, "I need to do what's best for the kids. Their father thinks living the life he used to [as a party kid] is okay while he raises kids. He wants to continue that life, and I do not. I don't want my kids growing up around that. So, it's time for me to move on."

Single mothers not in a relationship or not living with their partners, however, were less likely to report negative parenting practices, such as losing their temper or hitting their children, than mothers who were married or who were single but living with their partners. Although the data on parenting practices are limited to mothers' self-reports, and it is likely that other factors are associated with parenting practices, this latter finding suggests that the internal dynamics of two-parent households—regardless of marital status—differ from those of single-parent households and, in some families, may increase the risk of mothers' negative parenting practices.

Table 28. Mothers' Positive Parenting Activities during Previous 3 Months by Selected Maternal Characteristics in Year 3[a]

Parenting Activities	All Mothers *(N=390)*	Education (%)		Race/Ethnicity (%)			Nativity (%)		Marital Status (%)		
		Not HS graduate (*n* = 214)	HS graduate (*n* = 176)	Black (*n* = 147)	Hispanic (*n* = 212)	White/other (*n* = 31)	Foreign-born (*n* = 223)	U.S.-born (*n* = 167)	Married (*n* = 118)	Single/live w/partner (*n* = 129)	Single or do not live w/partner (*n* = 143)
Read books to child	93	91	96*	95	91	94	91	95	93	91	94
Told stories to child	87	85	88	89	84	90	86	87	87	84	89
Sang songs with child	93	90	97**	97	90	97*	93	94	96	90	94
Took child on errands	99	99	99	97	100	100*	100	98	100	99	98
Took child outside for walk or to play in yard, park, or playground	96	95	97	98	95	97	96	96	96	96	97
Played with clay, drew pictures, or did other arts and crafts with child	76	68	86***	80	71	94**	71	83**	81	71	78
Played games, puzzles (Y2)	72	67	80**	80	66	77*	66	80**	78	63	77**
Took child to library (Y2)	28	21	37**	37	23	25**	22	37**	35	17	34**
Did household chores with child (Y2)	71	65	80**	73	69	81	63	82***	72	64	78*
Praised child	99	100	99	99	100	100	100	99	100	100	99
Encouraged child to read a book	88	86	90	91	85	90	85	91	92	83	88
Talked to child about a television program (Y3)	71	66	78*	77	67	75	66	78*	72	68	74
Mean Positive Parenting Score (range: 0-1)[b, c]	**.91 (*.13*)**	**.89 (*.15*)**	**.94 (*.10*)*** **	**.93 (*.11*)**	**.90 (*.14*)**	**.95 (*.10*)** **	**.90 (*.13*)**	**.93 (*.12*)***	**.93 (*.11*)**	**.89 (*.15*)**	**.92 (*.12*)***

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Mean parenting scores are based only on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3. One-way ANOVA tests indicated means are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

[c] Mean differences in positive parenting by race/ethnicity and marital status were examined with the Bonferroni post hoc test, which uses *t*-tests to perform pairwise comparisons between group means, but controls overall error rate by setting the error rate for each test to the experimentwise error rate divided by the total number of tests. Hence, the significance level is adjusted for the fact that multiple comparisons are being made. The mean for married mothers was significantly higher than the means for both single mothers living with a partner and single mothers not in a relationship or living with a partner.

Chi-square tests of individual parenting items indicated that differences between or across subgroups are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

Table 29. Mothers' Negative Parenting Activities during Previous 3 Months by Selected Maternal Characteristics in Year 3 [a]

Parenting Activities	All Mothers *(N=390)*	Education (%)		Race/Ethnicity (%)			Nativity (%)		Marital Status (%)			Employment (%)	
		Not HS graduate (*n*=214)	HS graduate (*n*=176)	Black (*n*=147)	Hispanic (*n*=212)	White/other (*n* = 31)	Foreign-born (*n*=223)	US-born (*n*=167)	Married (*n*=118)	Single/live w/partner (*n* = 129)	Single/not w/partner (*n* = 143)	Not working (*n* = 198)	Working (*n* = 192)
Lost temper with child (Y2)	53	58	47*	28	70	52***	63	39***	56	62	43**	57	49
Found hitting or spanking a good way to get child to listen	31	32	29	19	40	19***	37	22**	37	38	20**	31	31
Got more angry than meant to with child	22	23	21	16	27	16*	24	20	23	27	18	18	27*
Punished child for not finishing food on plate	6	6	5	7	4	9	4	8	4	7	6	9	3*
Blamed child for something not child's fault	10	8	14*	8	11	16	10	10	13	9	9	11	10
Mean *(SD)* Negative Parenting Score (range: 0-1)[b, c]	**.17 *(.21)***	**.17 (*.20*)**	**.17 (*.23*)**	**.12 (*.19*)**	**.21 (*.21*)**	**.15 (*.31*)****	**.19 (*.21*)**	**.15 (*.22*)**	**.19 (*.24*)**	**.20 (*.22*)**	**.13 (*.19*)****	**.17 (*.22*)**	**.18 (*.21*)**

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Mean parenting scores are based only on parenting items included in all three surveys. (Y2) and (Y3) indicate items added in year 2 or year 3. One-way ANOVA tests indicated means are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

[c] The Bonferroni post hoc test indicated that the mean negative parenting score was significantly higher for Hispanic mothers than for Black mothers and significantly lower for single mothers who were not in a relationship or living with a partner than for mothers who were married or living with a partner.

Chi-square tests of individual parenting items indicated that differences between or across subgroups are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

Table 30. Mothers' Year 3 Parent Involvement Activities during Previous 3 Months for Children in Childcare or School by Selected Maternal Characteristics[a]

Parent Involvement Activities	All Mothers *(N=291)*	Race/Ethnicity (%)			Nativity (%)		Marital Status (%)			Employment (%)		Year 1 Teen Mother (%)	
		Black (*n*=125)	Hispanic (*n*=139)	White/other (*n*=26)	Foreign-born (*n*=157)	U.S.-born (*n*=133)	Married (*n*=86)	Single/live w/partner (*n* = 81)	Single/not w/partner (*n* = 124)	Not working (*n* = 111)	Working (*n* = 180)	Teen (15-19) (*n* = 37)	Non teen (≥ 20) (*n* = 253)
Helped child with homework	50	47	56	35	50	50	63	52	40**	68	39***	16	55***
Attended a parent-teacher conference	52	42	61	42**	58	44*	63	59	39**	69	41***	11	58***
Talked to teacher about child's progress at other times	69	66	71	73	68	71	71	75	65	76	65	41	74***
Attended field trip or family event at child's school/center	37	32	43	27	39	35	49	40	27**	48	30**	8	41***
Attended PTA meetings at child's school or center	34	30	40	15*	40	26**	48	31	25**	48	24***	5	38***
Mean *(SD)* Parent Involvement Score (range: 0-1)[b, c]	**.48 (*.37*)**	**.43 (*.35*)**	**.55 (*.38*)**	**.39 (*.34*)***	**.51 (*.38*)**	**.45 (*.35*)**	**.59 (*.38*)**	**.52 (*.35*)**	**.39 (*.35*)*****	**.62 (*.32*)**	**.40 (*.37*)*****	**.16 (*.23*)**	**.53 (*.36*)*****

[a] Sample includes only mothers who have children in childcare or school. Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Mean parenting scores are based on all parent involvement items in the year 3 survey. One-way ANOVA tests indicated means are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

[c] Bonferroni post hoc tests indicated that the mean parent involvement scores were significantly lower for single mothers and those not living with their partners compared with mothers who were married or with those living with a partner, for working mothers compared with mothers who were not working, and for teen mothers compared with older mothers.

Chi-square tests of individual parenting items indicated that differences between or across subgroups are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$.

For mothers who had children in school or childcare, additional differences in school parent involvement activities were found to be associated with characteristics such as maternal age, employment status, and marital status. For example, as shown in Table 30, mothers who were not working were more likely than mothers who were employed to talk to their child's teacher ($\chi^2 = 3.89$, $p < .05$), help with homework ($\chi^2 = 19.76$, $p < .001$), attend parent-teacher conferences ($\chi^2 = 21.41$, $p < .001$), go on field trips or family events, ($\chi^2 = 9.03$, $p < .01$), or attend PTA meetings ($\chi^2 = 17.28$, $p < .001$). This is consistent with other research suggesting that parent employment is an important predictor of parent involvement in Head Start programs compared with other parent characteristics (Castro et al., 2004).[38] In addition, mothers who were 20 or older when the focal child was born were more likely than teen mothers to help their children with homework ($\chi^2 = 19.76$, $p < .001$), attend parent-teacher conferences ($\chi^2 = 29.96$, $p < .001$), go on field trips or family events ($\chi^2 = 15.67$, $p < .001$), and attend PTA meetings ($\chi^2 = 14.98$, $p < .001$).

Table 30 also indicates that, overall, married mothers and single mothers living with a partner were more likely than single mothers without partners to be involved in their children's school or childcare activities. Moreover, married mothers reported higher rates of some activities than single mothers with or without partners. For example, helping with homework was an activity reported more often by mothers who were married (63%) than by mothers who were living with partners (52%); single mothers living with partners, in turn, were more likely to help with homework than single mothers without partners (40%) ($\chi^2 = 10.38$, $df = 2$, $p < .01$).

Once more, we caution readers not to draw causal inferences about the relationships between parenting practices and the sociodemographic characteristics presented here, because many of these characteristics—age, education, race/ethnicity, nativity, employment, marital status, and income—are related to one another. Nor are these all of the factors that are likely to be associated with parenting practices. As data from the embedded qualitative study suggest, there are a number of other factors in the everyday lives of the study families that affect their parenting decisions and ability to care for their children in complex ways, including their beliefs and values. We explore some of these factors in the next section.

Emerging Themes: Factors that Shape Parenting

> *I'm the parent. I'm supposed to sacrifice everything I absolutely can to make sure that these kids have what they need and that they're happy.*
>
> ~Miriam, 26, mother of three

In the qualitative interviews, mothers spoke indirectly about their parenting beliefs and values as they described their daily routines and other domains of their social, cultural, and physical ecology. From mothers' accounts of their caregiving activities, childcare preferences, family background, aspirations, neighborhood and home environment, we were able to construct their views of parenting and the basis for their decision making. For instance, when mothers talked about their childcare decisions, they also spoke about their child-rearing values and attitudes, as when

[38] Castro and colleagues also report that parent education was a predictor of Head Start parent involvement, although the bivariate analysis did not show a significant difference in parent involvement between mothers who had or had not graduated from high school.

Miriam, a 26-year-old mother of three children under the age of 2, told us she was "trying my *hard*est not to put [the children] in day care." Similarly, when mothers spoke about their aspirations for their children, they asserted their values regarding education, career, and good morals.

In this section, we provide a glimpse of the needs, circumstances, and goals of selected mothers that influence their parenting practices, based on an analysis of three waves of interview data over a 12- to 15-month period starting around the focal child's first birthday. These accounts show how mothers weave together multiple domains of their lives, including childcare, domestic work, family support, service use, and paid work, in an effort to sustain their families. The particular cases presented here were chosen not so much because the details of their lives were the same as other mothers but because underlying values and beliefs about parenting that they portray and the influences on parenting practices are representative of important themes emerging from the qualitative data. For example, each of these cases illustrates the mother's overarching commitment to the well-being of her children, which is a dominant theme underlying the organization of the daily lives and decision making of all of the study families. They also illuminate the different levels of factors that collectively influence mothers' ability to parent their children—the individual needs of children; the family context, such as the stability of work, income, and childcare; and the neighborhood context—as well as how a change in one of these factors can diminish or improve their parenting.

Children's Needs

We first present the case of Neena, a 24-year-old mother of a 2-year-old boy, Enrique, with spina bifida. Neena's daily schedule is marked by complex activities driven by her son's physical needs. Her day-to-day tasks include going to several medical appointments, draining Enrique's urine, and exercising his legs to strengthen his muscles. Neena's accounts of how she spends her days both explicitly and implicitly conveyed that Enrique's needs come first, as did her comment that, "First, I take care of him and then take care of the rest." The day-to-day emotional demands of caring for Enrique entailed in the priority given to her child's well-being seem to have taken their toll on Neena, as evidenced by the interviewer's field notes summmarizing the mother's accounts of her ongoing battle against depression over the year. As the mother of a child with special medical needs, Neena's story is more unusual than a majority of the sample. However, her belief that, as a mother, she must take care of the needs of her child before her own is very representative of other mothers in the qualitative study (see Box 1).

Neena has resources for and access to medical care. It also appears that she receives some informal support from her husband, friends, and her church. Although she is the primary caregiver, her husband supports the family financially. He also encourages her to let their son interact and play with other children even if he cannot do everything they can do. On the other hand, Neena's emotional health needs seemed to be neglected at the time of each qualitative interview, suggesting that the day-to-day activities associated with taking care of a special needs child and worries about his future have taken a toll. Neena acknowledged feeling emotionally and physically drained and overwhelmed in the third interview, but she was also aware of the negative influence of her mental health on her interactions with her child.

Box 1. Neena
"Primero cuido a el, despues cuido el resto
[First, I take care of him and then take care of the rest]."

In wave 1 of the qualitative study, the biggest challenge for 24-year-old Neena was caring for a 14-month-old child with spina bifida. An immigrant from Mexico, Neena was very concerned about how Enrique, her only child, would develop, whether he would be able to go to school like other children, and generally what to expect from his life. She described her worries and hopes that he would be "normal" and be able to enjoy life:

> I ask myself what I am going to do with him. Or I think, "Will I have to put diapers on him?" There are times I start to think, how is he going to school, or how will he feel? Or I think that he can't walk, or that he wants to and can't. Well, there are times when I think it is better not to think because I will get depressed.

By the second wave, the interviewer noted in field notes that Neena's psychological state seemed to be increasingly affected by Enrique's care. Neena had to be with him constantly and could not leave him. Taking him to doctors and his therapist, carrying out his therapy at home every day, and helping him to do the activities that other children his age can do was more than a full-time job. Neena was feeling the stress physically and emotionally. She reported being unable to sleep well at night because Enrique woke a lot and cried or because she had to wake up to change his catheter. Physically, she was having serious back and shoulder pains, which her doctor said were stress-induced, and was often tired. Mostly, she said that she was feeling the stress emotionally. She said she often thinks about his condition and that he will never be able to live normally and gets depressed for him. She also mentioned sometimes not wanting to get up in the morning and feeling very alone taking care of him. She told the interviewer she thought her depression affected her interaction with Enrique. She said that when she gets sad, she doesn't pay as much attention to him and his needs. Neena says that no doctor or therapist has ever asked her about her psychological condition. When asked if she had considered counseling services, she said she tells herself she needs to get through it. She talks to her priest or possibly a friend, but mostly she just cries a bit and then pushes on through.

Although Neena did not reveal much depression or stress in the annual structured surveys, her emotional health was a consistent topic in the qualitative interviews. In the third interview, about the time of Enrique's second birthday, Neena did not shy away from talking about her feelings:

> Well, yeah, I would get (depressed), and I still get really sad. When he sees the other kids, when I take him out like to parties, I say to my husband, "While I can, I am going to go out with him." But it really gets frustrating; [Enrique] wants to do what the other kids do. And [my husband] says, "Let him go to play with them." I say to him, "He can't do it. He can't walk." And I still get sad and keep worrying, but, hey, what do I gain from worrying. A [neighbor] says, "Just resign yourself already," I tell her, "I can't." No, it worries me still. If I know that he can't, I should just, like they say, get used to it."

At the third wave, Neena was still talking about her depression and the complexity of her daily routine. However, she also reported that she had started English classes at a local nonprofit community program after Enrique stopped his twice-a-week physical therapy. Neena's main motivation to learn English was that it would help her communicate better with people at the clinics, doctors' offices, transportation providers, and her son's therapists. With the bit she has learned, she can now fill out forms better and talk to the staff more. As she told us: "When I arrived here [the U.S.], I didn't even know how to fill things out. And now, at least, when I see them (forms) I know it says where to put your phone number, or cellular, or of the house, or the address. Or the date, or the day that my son was born, or my birth date."

Importantly, Neena has taken the initiative to improve her situation and enroll in English language classes, which she believes will help her in applying for services. At the same time, Neena is an example of some mothers in the qualitative study who are worried about their children's development. (Another example is Holly, who was quoted in the previous chapter talking about her concerns about her son's language development.) If we were to offer a recommendation for additional services for this mother, it appears that she might also benefit from counseling for her depression or from participating in an education or support group for parents of young children or one focused on children with developmental disabilities.

Family Circumstances: Work, Income, and Childcare

Miriam's story, presented in Box 2, likewise illustrates a parent's commitment to her children as she describes her struggles with childcare and food insecurity. At the time of the third qualitative interview, Miriam was planning to leave her partner and move in with her mother. This was because of concerns about her partner's substance abuse and his unwillingness to put their children's needs ahead of his. She was trying to save enough money to afford out-of-home childcare when she moves in with her mother, while still hoping to obtain another childcare subsidy, which, in her words would be "the light in all this darkness." At the same time, she yearns to reestablish her routine with her children, hoping to do so when she moves: "So we'll be just fine, you know. Give them dinner, give them baths, send them to bed."

In Miriam's case, the tumultuous relationship with her partner and father of her children, decreasing economic security, and the change in her employment status are some of the factors that have shifted Miriam and her children's daily routine to a direction that not only is difficult to sustain but also conflicts with her values. Her new routine means working long hours, spending less time with her children, and worrying about their welfare. It also appears that the service system has not served all of Miriam's needs. The child welfare program, DCF, responded when it appeared that she and her partner were unable to properly care for their children by providing Miriam with a childcare subsidy. However, it ran out just as she had taken on a new job, because it was limited to six months. Back on the waiting list for a subsidy, she could not afford to keep her children in their care arrangement. At the third interview, Miriam acknowledged the probability that DCF would get involved with the family again. Given the instability of Miriam's childcare arrangements, a recommendation for services for this family might include a prevention plan involving continuing contact with a social worker and continuing funding for childcare (or help finding alternative, less expensive care), which might enable this family to sustain its daily routine until the mother is more self-sufficient.

Neighborhood Context

As the examples above indicate, mothers' decision making in the areas of their children's activities, childcare arrangements, employment, and service use is tied to the welfare of their children. Another influence on mothers' parenting practices is their neighborhood environment, including the availability of transportation, which directly contributes to their decisions about where they allow their children to play to ensure their safety and well-being. Mothers who live in high-crime neighborhoods and who lack ready means to leave their neighborhoods often make choices aimed at protecting their children

Box 2. Miriam:
"The kids eat first and foremost in my book."

"The typical day – we get them (the children) out of bed around 8:30 a.m…We bring them downstairs. We just play a lot, we read to them, we give them breakfast." This is how Miriam, a 26-year-old mother of 18-month-old twins described the start to her day in the first qualitative interview. She explained that her and her partner's goal was to find jobs that would allow one of them to be home with their children every day: "I really am trying my hardest not to put them in day care …to have myself and my fiancé raise them. That is my goal". She opted to pursue a career in real estate hoping for such flexibility. Because the family was struggling financially, extra income was needed. "Yes, I would say we are struggling. The goal was for me to be a stay-at-home mom and for him to provide and we're realizing that it's not gonna work out no matter how bad we want it."

Six months later, at the second wave, Miriam had given birth to another baby, and the family was facing a harsher economic reality. Her partner's income as a cook was not enough to cover household expenses, especially during the nontourist seasons. She had not been able to sell any properties and was trying to patch together childcare so she could work as a waitress at night. They were 4 months behind in their rent. Through Family Central, Miriam said she was able to secure 6 months of childcare subsidies for her 18-month-old twins. She felt her children were learning at the childcare center, but she missed being with them. "I enjoyed spending time with them; now I pick them up from daycare; we have dinner and go to bed."

When interviewed in the third wave, Miriam continued to describe her "normal" day as one of "waking up, playing with the kids, and having breakfast. Playing some more, having some lunch, taking a nap. Then we wake back up, we play. Around 7:00 we have some dinner, take a bath, and go to bed." She also, however, revealed plans to leave her partner and move in with her mother because of his substance abuse. She described a prior incident involving DCF when she was pregnant with her new baby. The twins had taken some of her boyfriend's sleeping pills, and Miriam had poorly assessed the situation. She thought the twins looked fine and went to work. Upon arriving home, Miriam realized one twin was unusually sleepy and took her to the hospital. DCF was called because Miriam waited too long to respond. Although Miriam tested negative, her boyfriend tested positive for several illegal substances. Her boyfriend was required to attend a treatment program but has not yet complied; nor has DCF followed up.

It was because of the family's contact with DCF that Miriam received the 6-month childcare subsidy; she also was assigned a social worker. However, soon after she started working 6 days a week at an upscale restaurant, the subsidy period ended. While on the waiting list for another subsidy, Miriam said she has no alternative but to leave the children with her boyfriend. However, she was clearly uneasy with this arrangement. "It is just over and over again, coming home to him drinking while the kids are in bed. They stay with him 'cause I don't have any other choice right now."

Despite Miriam's income, daily life is marked by food insecurity as her partner's contribution has dwindled. She receives both food stamps and WIC, but the food is quickly gone, often consumed by her boyfriend. Everyday she tries to fill herself with free food at work so she does not have to eat at home. Her children's needs come first:

> I don't care if I don't have food in my stomach, let there be food for the kids. I don't care if I have to live on the couch for the rest of my life, let the kids have what they need and want. I'm the parent, I'm supposed to sacrifice everything I absolutely can to make sure that these kids have what they need and that they're happy. And to him [partner], it just doesn't register the same way. We'll be low on food, so I just won't eat [but] he'll eat the snacks that I bought for the kids. The kids eat first and foremost in my book. I will call my mom and tell her, "Look, I don't have any food. I didn't eat today," and she'll bring me something. But I'm not gonna eat what I have here, because that goes to them. He just doesn't see it that way. So, there's nothing I can do. It's a battle I'm not gonna win.

from harmful influences, but by so doing, they also limit their children's activities to the home area. These mothers usually talked about staying at home watching TV, playing video games, and playing with toys. One example is Abigail, presented in Box 3, who stated that she hates seeing her daughter having nothing to do or having to do the same activity over and over again because it is not safe to take her outside.

Box 3. Abigail
"I hate to see her [without something to do]. She just sits there, and we play the same game or do the same thing over and over, you know."

Abigail is a 27-year-old married mother of a toddler, Denise, who lives in a neighborhood known for crime and drug trafficking. This mother, an émigré from Jamaica, is very aware of her neighborhood troubles. She reports trying to synchronize outside play with periods of low criminal activities in her neighborhood. When first interviewed, Abigail talked about the unfortunate need to restrict Denise's activities to the home. "I would love to take her to the park, but I can't take her out here. We hardly have outside activities, which I would love to do. But outside is too violent." Abigail's plaintive description of figuring out other activities to entertain her daughter reflects her frustration with the current circumstances.

> I bought some stuff because we home all day, to make, you know, keep the activity going, but…Yeah. I would like, um, some experience—somebody tell me like what could you do, you know, to make—Because I hate to see her like…she just sit there, and we play the same game or do the same thing over and over, you know.

When Abigail's car is running, she is able to expand her child's activities. "Last week [when the car was running] we was at the water park. It's just right there. We went down there. But we usually go to the Farmer's Garden Mart 'cause it has a lot of thing there.

Six months later, Abigail used the same rhetoric: "[On the weekends] Nothing. Stay in the house. Nothing same, we repeat the same routine.... But we repeat the same routine over and over. Just stay in the house." Being restricted to the home also coincides (Sense clear?) with Abigail's perception of her neighborhood safety: "A lot of violence more. It happens like every week. Every day something happens. I think last month they killed over four people."

One year after her first qualitative interview, however, Abigail spoke, though hesitantly, about feeling safer in her neighborhood: "It has been good. I don't hear no violence in the Glades for a long while. Maybe I talk too soon but it has been real good…. We have new patrol cars on the road and stuff like that so it has been real quiet. Nobody got killed, no ambulance, it has been real good." Abigail reported feeling comfortable walking to the store or catching a bus, a contrast with her earlier reluctance to go outside at all. Her perception of a safer neighborhood, moreover, has led to a decision to allow Denise to play outside. "Me and Denise we even ride our bike outside or we ride her bike in the yard where she can ride her bike so it is good. It is way better."

Another example is 21-year-old Bayle, an African American single mother of three children ages 2, 3, and 4 years, and who described herself as an "overprotective" mother. She explained:

> I never let them play with a whole lot of people, a lot of kids out here because of the mentality of people growing up in places like this. I really don't want them to grasp a hold of it.… Like projects, ghettos.… The guys have their pants hang down low and the gold all in their mouth, the long dreds. They carry guns out here, they sell drugs. That is what I am talking about.

Unfortunately, unlike Abigail, Bayle's perception of the safety of her neighborhood did not improve over the course of our first three interviews with her. At each interview, she repeated the same unhappy litany of living in a troubled neighborhood and staying at home.

Like Abigail and Bayle, other mothers in the qualitative sample talked about the dangers in their neighborhoods and how they limit the activities they can do with their children. At the same time, as indicated by survey data showing a decline in negative housing conditions, some families reported feeling safe in their neighborhoods as a result of better security in the community or the family's move to a new neighborhood. In the case of the latter, mothers described the activities they can do with their children that were not possible in their old communities, such as going to the park, walking around the block, playing outside, and going to the library. Elvia**,** a 22-year-old mother of one child, illustrates this when she talks about the positive effects on her daily routine of moving to a new neighborhood. In her new home and neighborhood, Elvia is able to expand the range of activities she can do with Pablo and, more importantly, is free from the stress fueled by her former troubled neighborhood environment.

> There is no danger, because where we were before, there was a lot of danger and here no… Here I don't hear that there are people who kill or steal. Now I can go out at night. Yes, every two hours I go out with my son going around in the streets…that is the difference, that I can go out more and there is not a lot of danger. And besides that, in the place where I am now, how can I tell you, the apartment is bigger. Now my son now can run, play… I take him out here more. He has more freedom here. That is the difference.

It should be recognized that our current data sources do not allow us to describe in much detail the actual neighborhood environments of the study families or the availability of public transportation and resources, such as parks and other recreational facilities, childcare, afterschool programs, and libraries. Mothers' responses to a survey question about neighborhood safety suggested that less than a fifth of the sample felt that their neighborhoods were "unsafe because of illegal activities." However, when mothers were asked to describe their daily routines and their children's activities in the qualitative interviews, their reports painted a somewhat different picture. The excerpts from interviews with the three mothers here and the reports of other mothers make clear that what makes a neighborhood a safe and healthy environment for raising children depends not only on concrete resources for activities for their children but also their perceptions and feelings of safety and well-being in their neighborhoods.

In some cases, mothers' perceptions change not because of real physical changes in the community but because they become more familiar with and comfortable with their neighborhoods over time or because their children become more self-sufficient with age. Mothers' perceptions may change as well as they learn more about activities that are available or

as they learn how to expand the activities they can provide for children at home. Indeed, when mothers describe their activities with their children at home, some seem to be very knowledgeable about the importance of playing games, reading books, and other activities with their children, but others seem less informed. These parents, especially those who do not have resources in their immediate neighborhoods and lack transportation to leave their neighborhoods, might be reached through home-based services such as the Parents as Teachers (PAT) and Home Instruction for Parents of Preschool Youngsters (HIPPY) programs; group parent support and parenting education programs held in convenient, local settings; and mobile activity vans that provide books, play materials, and literacy activities.

Goals for Children

As the preceding sections suggest, parenting practices are influenced by the individual needs of children, family circumstances, and neighborhood contexts, among other factors. Other underlying factors are parents' expectations of and goals for children, which parents instinctively express as they describe their daily routines, children's activities, and children's development. Mothers were asked in the qualitative interviews about their expectations of and aspirations for their children at different points in time. Across the first three waves of qualitative interviews, we find consistency in mothers' goals for their children, although there may be changes in the way they meet these goals in response to changes in children's development, in family work and economic circumstances, and in neighborhood environment.

When mothers spoke about their aspirations for their children, they talked about education, work, careers, and good morals. Despite mothers' different ecological and cultural contexts and demographic characteristics, their aspirations for their children were remarkably alike. Their goals fell into two general areas: (1) moral and social development and (2) education and future work. In the first area, mothers expressed goals for their children such as the following: "be really respectful," "respect people," "be polite and have manners," "be a good person," and "have responsibility."

In the area of educational achievement, mothers typically talked about wanting their children to "be a good student," "go to college," "finish school," "graduate from college," and "have a career." The value which Angelica, who was described earlier, places on education clearly emerged when she described her involvement in her children's education by taking trips to the library, having conferences with her older son's pre-school teacher, reading to her children, and having her children prepared for the third-grade state achievement test. Along with her own plans to finish her schooling and have a career in criminal justice, she envisioned the educational paths of her children: "In the future my kids will be in college and high school." The high value Angelica placed on education extended to her goal of keeping her children from unhealthy relationships when they reach adolescence so that they can focus on their schooling:

> I don't want my kids to be in relationships when they are teenagers. I had one and it is not good because you don't focus on your main priorities. If Natan would have a girlfriend as a teenager that isn't focusing him. He will worry about what his girlfriend thinks instead of what he wants to go to college for or what college he wants to go to. I want [him] to be more focused on that. I want him to be in basketball. I told him, "You will have your time for worry about girls. Your

> whole life you have to worry about where you want to put your life, what you want to do when you are 21 years old. [Some] people finish high school and don't know what they want to be." I don't want him to do that. I want him to know as soon as he finishes high school what he wants to do. "I want to do this 'cause I want to be a fireman, I want to be a police officer, I want to be a doctor, I want to be a lawyer. I don't care what you want to be. As long as you know what you want to be in life I am all right." And my daughters, too.

Marta, a Cuban- American married mother of two children, also hopes her children will study and go to school. Marta believes that success in school is contingent on what children learn at home. "It is about how you raise them. That would be the main point because you can put them in the best school you can put them in but if you are not giving them the right education from home you are not doing anything." Marta's educational values are congruent with her family decision to remain in the same school district. At the time of Marta's first interview, she was planning to move to a neighborhood where she could have a bigger house and be closer to her family. After six months, though, Marta explained that she decided against the move because she did not want to jeopardize her children's schooling. She explains, "When you have kids, you have to be careful where you move and the school." Marta is extremely happy with the schools in her district and is aware that her decisions would directly affect her children. "…Sometimes you have to hold off from things because of your kids." Moreover, Marta tells us: "…When you make a decision, you don't make it for yourself anymore. It is them [children]." Marta echoed the same educational values over the course of her three qualitative interviews.

Some mothers talked about equipping their children with good values so their children will grow up to be morally upright individuals. They believe that raising children with good manners and morals will help them succeed in life. For example, Gloria, a 23-year-old single mother of four children between the ages of 1 and 5 years, believes that children who are raised with love and affection will grow up "to be good people." Gloria teaches her children to respect others and to conduct themselves in a respectful way and to have good manners. Although Gloria vows to do her best to help her children "finish school," she hopes most of all that they will become respectful adults no matter what life course they choose to pursue.

> So I see my kids growing up to be more, you know. That's the way I feel. I don't care whether they work at McDonald's. They work wherever they want to. You choose that. You wanna work there—I would try my best to make them finish school. But if they decide not to and… I mean, I would push the issue as far as I can. No, school is good, you know. But if they work at McDonald's and you meet them, they will not show you that they're a McDonald's worker. They're gonna show you that they look like they work in an office or something. That's why I want my kids to be … I want my kids to know, you know, how to speak to somebody respectfully…. That's a big issue with me. It's like your first [impression], you know, is the best …your first reaction to a person when you meet, you know, the person, you gotta make yourself.

Gloria's attention to "make an impression" conforms to her description of the grooming of her children preceding their appointment at the WIC office: "I got up, I took them all of that. I, you know, put their clothes on, made them look really nice. Did their hair, you know, everything."

Mothers' aspirations for their children are based on their own life experiences and a desire that their children have better opportunities than they had or that they not make the mistakes they did. For example, in the excerpt above, Angelica gives the following explanation of why she does not want her children to be in relationships when they are teens: "I had one and it is not good because you don't focus on your main priorities." Similarly, Shirley, a 21-year-old mother of two toddlers, whose partner was killed shortly before her interview, expressed her concern about the influence of outward drug use and other criminal activities in their neighborhood on her older, 2-year-old:

> To be 2 she knows too much. I'm tryin' to break her now, before it gets too late. 'Cause I know that's how I grew up. I don't want her to grow up like that. And then, I always wanted my kids to have a daddy. Even what we used to go through, I used to always tell him that, "Ray you don't gotta be with me, you just be there for my kids."
>
> And that's why I think … everything that I want, it don't never go right. I guess I wanted it too bad, wanted him to be here with my kids too bad. But, they're okay. I just gotta break them. I can't just let my babies get killed out here and go through this. 'Cause it was every night somebody gettin' killed [around here].

Summary

Mothers were asked to report on three general kinds of parenting practices that they and their husbands or partners used during the 3 months prior to the third-year survey: positive activities with their children in their home and neighborhood, negative parenting practices, usually for disciplinary purposes, and parent involvement with their children's school or childcare. More than three-quarters of the mothers reported that they engaged in a variety of positive parenting activities, which included taking their child on errands, praising their child, taking their child outside to play, singing songs with their child, reading books to their child, encouraging their child to read a book, and doing art activities with their child. For families in which husbands or partners had contact with their children, mothers reported that about two-thirds or more of fathers engaged in most positive parenting activities.

Smaller percentages of mothers reported that they or their husbands/partners used negative parenting practices. Just over half (53%) of mothers reported that they had lost their temper with their child; almost a third (31%) said they had found hitting or spanking their child was a good way to get the child to listen; and less than a fourth (22%) said they got angrier with their child than they had intended during the previous 3 months. No more than 10 percent said that in the past 3 months they blamed their child for something that was not the child's fault or punished their child for not finishing the food on their plate. Mothers whose husbands or partners had had contact with their children reported somewhat lower percentages of negative parenting practices for their husband or partner than they reported for themselves.

Over time, positive parenting activities increased for both mothers and fathers, but most of the changes occurred between the first and second year. The only noteworthy difference between year 2 and year 3 was an increase in the percentage of mothers who reported engaging in art activities, such as playing with clay and drawing pictures, which, again, is consistent with the increasing age of their children. Although reported activities of fathers were very similar in year 2 and year 3, there was a decline in the percentage of fathers reported to encourage their child to read a book. In terms of negative parenting practices, there were no significant changes in mean negative parenting scores for mothers or their husbands/partners between years 2 and 3.

Parent involvement activities are less likely to occur as frequently as other kinds of parenting activities in the survey. The most frequent parent involvement activity was talking with their children's teachers, which was reported by over two-thirds (69%) of the mothers. About half of the mothers had attended a parent-teacher conference, and about half had helped their child with homework during the previous 3 months; more than one-third reported that they had participated in a field trip or school event for families or attended a PTA meeting. Except for helping with homework, the percentage of fathers who engaged in any of these activities was smaller than the percentage of mothers.

We also found associations between parenting practices and a number of family characteristics, including educational background, race/ethnicity, and immigrant status, although it is important to keep in mind that many of these characteristics are highly correlated. Other significant associations suggest that maternal employment, marital status, and cohabitation may also influence mothers' parenting practices. For example, mothers who were married were more likely to report use of positive parenting practices and less likely to report use of negative parenting practices than mothers who were single but living with a partner. Single mothers not in a relationship or not living with their partners, however, were less likely to report negative parenting practices, such as losing their temper or hitting their children, than either mothers who were married or who were single but living with their partners. Although these data are limited, they suggest that the internal dynamics of two-parent households differ from those of single-parent households and, in some families, may increase the risk of mothers' negative parenting practices.

To learn more about the factors that influence parenting, including mothers' underlying beliefs and values, we turned to the qualitative data. From mothers' narratives of their daily routines, caregiving activities, childcare preferences, neighborhoods, social support, service use, and aspirations, we were able to construct their views of parenting and the basis for their decision making. We found that a dominant theme underlying the organization of the daily lives and decision making of all of the study families was mothers' overarching commitment to the well-being of their children. This factor stood out among other important influences, such as the stability of food, work, income, and childcare, on the decisions mothers make to sustain their families.

CHILDCARE ARRANGEMENTS

An increasingly important support for the study families, especially working parents, is childcare for preschool and school-age children. In the third year, a total of 218 mothers, representing 308 preschool-aged children, used some form of childcare, defined as care on a regular basis from someone other than a parent. This amounts to more than half (56%) of the mothers in the year 3 sample and corresponds to an increase from 51 percent reported in the second-year interview and 23 percent in the baseline year (see Table 31).

More than three-fourths (80%) of mothers using childcare said their children were in their childcare arrangements 5 days a week. The number of hours spent in care per week ranged from a low of 5 hours per week to a high of 90, although less than 5 percent spent more than 50 hours in childcare each week. Typically, each child spent about 38 hours a week in childcare. These results show a slight increase in the percentage of children in full-time childcare and the number of hours spent weekly in care from the previous year, when 70 percent of children receiving care did so 5 days a week and the average time per week in care was 35 hours.

Care Arrangements for Preschool Children

Mothers reported use of a variety of nonparental care arrangements in the third year of the study. Informal care by relatives, friends, and neighbors and formal arrangements, which include center-based programs and family childcare, were represented almost equally (see Table 31). The two most frequently reported types of nonparental arrangements were center care (24%) and care by relatives (19%). Care by a friend or neighbor was the form used next most frequently, by 11 percent of the sample. This represents a change in the form of nonparental care from the first two years of the study, when relative care was used more frequently than other forms. Of the children who were cared for by relatives or friends/neighbors, more than half (60%) received this care outside their home, compared with 43 percent in year 1 and 57 percent in year 2.

Table 31. Primary Childcare Arrangements for All Preschool Children over Time[a,b]

Childcare Arrangement	Study Year (N = 390)		
	% Year 1	% Year 2	% Year 3
Parent at home	77	49	44
Relative	13	21	19
Childcare center/Head Start/Pre-K	8	18	24
Friend/neighbor	2	11	11
Family childcare	2	3	8
Other/someone else	1	0	1
Multiple arrangements[c]	1	1	4

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."

[b] In year 3, there were 218 mothers, representing 308 children, who used nonparental care. In a large majority (94%) of these families, the focal child was in childcare.

[c] Mothers using multiple arrangements used only two types of care. The most frequently reported combination was relative care and center care; the next most frequent was a combination of relative care and family childcare.

*Pairwise *t*-tests showed the following differences were statistically significant at $p < .05$ or less: parent 1 versus parent 2, parent 2 versus parent 3, relative 1 versus relative 2, friend 1 versus friend 2, family childcare 2 versus family childcare 3, center care 1 versus center care 2, center care 2 versus center care 3, and multiple arrangements 2 versus multiple 3.

These changes in the types of arrangements over time likely reflect the older age of the children and mothers' growing comfort with out-of-home care, as well as the greater availability of childcare options for older children, as mothers seek employment and return to work.

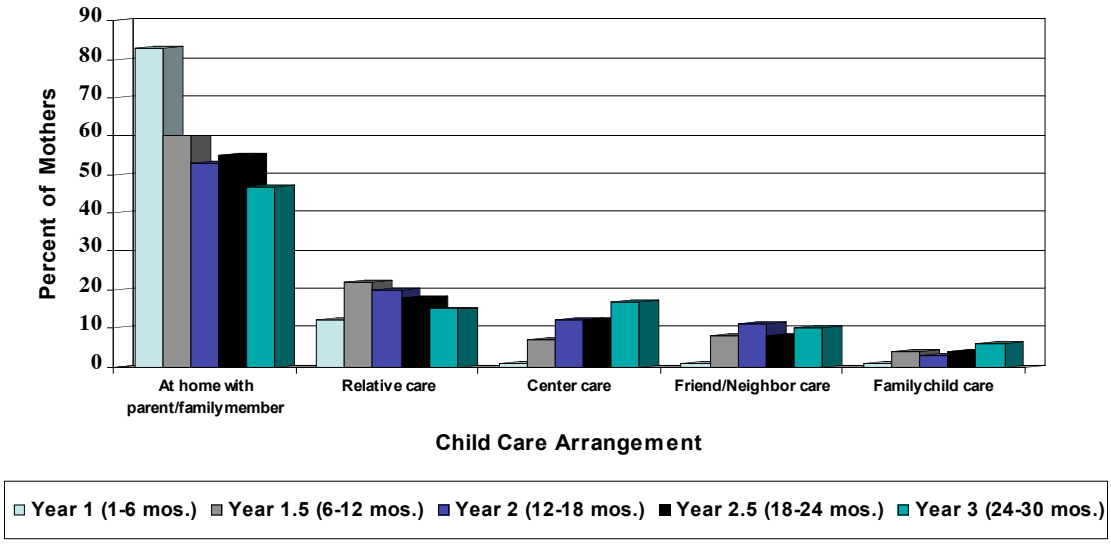
More than half (53%) of the focal children were in some form of nonparental care arrangement at the time of the year 3 interview (see Table 32 and Figure 2). This represents an increase from the second year when 47 percent of the focal children received care from someone other than a parent and from the baseline year when only 17 percent of the focal children were in care. Again, the most frequently reported type of nonparental childcare arrangement for the focal children in the third year was center care (17%), followed by relative care (15%) and care by a friend or neighbor (10%). In other words, the focal children were about as likely to be in an informal as a formal childcare setting between 24 and 30 months of age.

Table 32. Types of Childcare Arrangements for Focal Child over Time[a]

Childcare Arrangement	Study Year and Age of Focal Child (N = 390)				
	% Year 1 (1-6 mos.)	% Year 1.5 (6-12 mos.)	% Year 2 (12-18 mos.)	% Year 2.5 (18-24 mos.)	% Year 3 (24-30 mos.)
At home with parent/family	83	60	53	55	47
Relative	12	22	20	18	15
Childcare center/Head Start/Pre-K	1	7	12	12	17
Friend/neighbor	1	8	11	8	10
Family childcare	1	4	3	4	6
Other/someone else	1	0	0	1	0
Multiple arrangements[b]	1	0	1	1	3

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] Mothers using multiple arrangements for the focal child used no more than two types of care. The most frequently reported combinations were relative care and center care, followed by relative care and family childcare
* Pairwise t-tests showed that all differences between year 1 and year 2, between year 2 and 3, and between year 1 and year 3 were statistically significant at $p < .05$ or less for each category of childcare arrangement.

Figure 2. Primary Childcare Arrangements for Focal Children Year 1 to Year 3



The qualitative data also indicated working mothers' increasing interest in out-of-home childcare arrangements as their children grow older. One factor is the greater availability of center-based programs such as Head Start for older children. For example, when Debra, a single mother in the Glades, began investigating childcare for her son so he could "interact with other kids" before he turned 2, the only center she could find that accepted children under 3 was 10 miles away, so she decided to continue with her informal arrangement. Another factor is the increased knowledge that mothers gain about childcare options from their personal networks. As we discuss later in this chapter, mothers who were recent immigrants seemed less familiar with the concept of out-of-home childcare and, hence, less comfortable with it when their children were young; but over time, as they learned more about it from relatives and friends, they became more comfortable with it.[39] Some immigrant mothers also began to see it as a way for their children to learn English and prepare for school. For example, Elvia reported learning about the concept of preschool from a relative: "My sister-in-law told me pre-school is a [program] where you take the kids where they teach them things before they start school."

The age of the child surfaced as another important factor mothers considered in making childcare decisions. Most of the mothers who talked about using formal childcare indicated that they preferred to wait until their children were about 3 years old before enrolling them in center care, because at this age, they expected their children to be able to communicate and control their behavior and bodily functions (e.g., use the toilet independently) sufficiently to ensure they received good care. The idea that a child's age works as a protective factor against poor quality care was expressed by Tania, a mother of an 18-month-old and a child in elementary school, who said that she wanted her younger child to be in care but planned to wait until "she's talking real good." She explained: "Some teachers don't treat them good. So, I'm going to put her in school when she can go to the bathroom on her own and is like talking reasonable."

Stability of Childcare Arrangements

Consistency in caregiving is generally considered to be an important factor in children's development, especially in the first few years of life (e.g., Bornstein, 1991; Landry, Smith, Swank, Assel & Vellet, 2001; Landry, Smith & Swank, 2006). We attempted to assess the consistency of childcare arrangements by looking at both the number of different arrangements and the number of transitions from one arrangement to another experienced by the focal children during the first 2 and one-half years of their lives. These were based on maternal reports at roughly 6-month intervals, which were obtained in the first three annual in-person surveys and the telephone surveys that occurred between each of the in-person surveys.

It should be noted that the number of childcare arrangements and the number of transitions in care are two different measures. A child may be in only two types of care arrangement, for example, parental care at home and a childcare center, but experience four transitions if placed in a different arrangement every 6 months.[40] For example, Miriam's

[39] Indeed, in at least one case, a mother was not even familiar with the concept of out-of-home care until the topic was raised in one of the qualitative study interviews. When asked by the interviewer about childcare, she responded, "I would like to know [what] day care is because honestly I don't know." The interviewer, in turn, told the mother, "A day care is like a school but the children are not learning how to read or write; it is more a place to be taken care of where they are going to be okay, like a school where you can leave them and you could go to work.."

[40] There also may be other instability in childcare arrangements that are obscured in the survey data, such as changes in the parent who cares for the child or changes in the particular childcare center used.

children, who were profiled in Box 2 in the previous chapter, were being cared for by their parents at the baseline interview, and then by a relative (Miriam's mother) 6 months later. Six months after that, the children were in the care of their parents again. Subsequently, they were placed in a childcare center for 6 months, but when Miriam's childcare subsidy ran out, they were back home with their parents again.

In terms of the number of different types of childcare, nearly three-fourths (73%) of the children were in fairly steady childcare settings, meaning that they were either in the same arrangement (31%) or were in no more than two different arrangements (42%) across the five time points (see Table 33). Most children who were in the same arrangement were at home with a parent or another family member. Children who were in two different arrangements most often experienced a mix of parental care and care by a relative. Nonetheless, although a majority of children experienced only one or two different childcare arrangements during the first two and one-half years of their lives, almost half (46%) of them had two or more transitions in care (see Table 34). Almost one-quarter (24%) experienced three or four transitions during this time.

Table 33. Number and Types of Focal Child's Care Arrangements between Birth and 2½ Years[a]

Number of Different Arrangements across Five Time Points[b]	Frequency	Percent
One	**121**	**31**
Child with parent	116	30
Child with relative or friend/neighbor	5	1
Two	**162**	**42**
Child with parent and either relative or friend/neighbor	116	30
Child with parent and either childcare center or family childcare	40	10
Child in two different, nonparental care arrangements	6	2
Three	**77**	**20**
Child in three arrangements involving parent, a childcare center or family childcare, and another informal caregiver	45	12
Child in three arrangements involving parent, relative, and friend/neighbor	24	6
Child in three different, nonparental care arrangements	8	2
Four or Five	**30**	**8**
Child in four or five different arrangements involving some combination of parent, relative, friend, childcare, or family childcare	26	7
Child in four different arrangements involving some combination of parent, relative, friend, and another informal caregiver	2	0.5
Child in four different nonparental arrangements involving relative or friend, childcare, and family childcare	2	0.5

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] The five time points include years 1 (1-6 mos.), 1.5 (6-12 mos.), 2 (12-18 mos.), 2.5 (18-24 mos.), and 3 (24-30 mos.).

Table 34. Number of Transitions in Focal Child's Care Arrangements between Birth and 2½ Years[a]

Number of Transitions across Five Time Points[b]	Frequency	Percent
None	121	31
One	88	23
Two	88	22
Three	64	16
Four	29	8

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] The five time points include years 1 (1-6 mos.), 1.5 (6-12 mos.), 2 (12-18 mos.), 2.5 (18-24 mos.), and 3 (24-30 mos.).

Correlates and Predictors of Childcare Use

Bivariate associations presented in Table 35 indicate family characteristics associated with use of childcare, including the work status of mothers, whether or not they are attending school or a job training program, and a variety of sociodemographic characteristics. A regression analysis of mothers' reports of childcare use was performed to determine the most important characteristics associated with use of childcare for any of their preschool children. The race/ethnicity and

Table 35. Use of Nonparental Preschool Childcare by Mother Characteristics[a]

Characteristic	Using Childcare	Not Using Childcare
TGA^		
% Glades TGA (*n* = 48)	71	29
% Non-Glades TGA (*n* = 303)	53	47
% Outside TGAs (*n* = 39)	56	44
Employment* **		
% Working (*n* = 192)	90	10
% Not working (*n* = 198)	23	77
School* **		
% Currently in school (*n* = 41)	83	17
% Not in school (*n* = 349)	52	48
Job training		
% Participating in job training (*n* = 9)	67	33
% Not participating in job training (*n* = 381)	56	44
Nativity* **		
% U.S.-born (*n* = 167)	68	32
% Foreign-born (*n* = 223)	47	53
Race/ethnicity* **		
% Black, not Hispanic (*n* = 147)	75	25
% Hispanic (*n* = 212)	41	59
% White/other (*n* = 31)	66	34
Education* **		
% Not HS graduate (*n* = 214)	44	56
% HS graduate (*n* = 85)	64	36
% Post-HS education (*n* = 90)	76	24
Partner status* **		
% Has husband/partner (*n* = 286)	51	49
% Does not have husband/partner (*n* = 104)	70	30
Number of children*		
% One child (*n* = 126)	62	38
% Two or more children (*n* = 258)	53	47
Income-to-poverty Ratio* **		
% At or below poverty threshold (*n* = 207)	47	53
% Above poverty threshold (*n* = 177)	66	34

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk." Chi-square analysis indicated that differences are statistically significant at ^$p < .10$, *$p < .05$, ** $p < .01$, or *** $p < .001$.

nativity variables were combined in the analysis to determine whether there were significant differences in use of childcare among U.S.-born Blacks and Hispanics, foreign-born Blacks and Hispanics, and "other" mothers. The indicator for residing in the Glades TGA was included because it is of particular interest in this study; it also was found to be a significant predictor of childcare use in year 2.

Results presented in Table 36 show that the factors that were associated with increased odds of using childcare included mothers' employment status, school status, nativity, race/ethnicity, and social support. The strongest predictors of childcare use are maternal employment and being in school. Mothers who were currently working were about 42 times as likely as unemployed mothers to use childcare. Mothers who were currently in school were more than ten times as likely to use childcare as mothers who were not currently in school. And mothers who were both working and in school were 74 times as likely to use childcare as mothers who were neither working nor in school.

We also observed racial/ethnic and nativity factors in childcare use. Mothers who are Black—both foreign-born and U.S.-born mothers—were much more likely to use childcare than foreign-born Hispanics. Although Hispanic mothers born in the United States had somewhat higher odds of using childcare than foreign-born Hispanic mothers, these were not statistically significant in the regression. In addition, mothers who reported more frequent support from family or friends were a little more likely to use childcare. Together, these factors explained about 62 percent of the variation in childcare use.

Table 36. Logistic Regression Predicting Use of Nonparental Preschool Childcare at Year 3

Predictor Variable[a]	Log	Odds Ratio	Sig.
Mother currently working	3.7	41.7	***
Mother currently in school	2.3	10.1	***
Mother currently works and is in school	4.3	74.2	***
Mother high school graduate or GED	0.1	1.2	*NS*
Mother has post high school education	0.1	1.1	*NS*
Household is at or below the poverty level	0.3	1.3	*NS*
In Glades TGA	0.8	2.1	*NS*
Currently has a husband/partner	-0.0	1.0	*NS*
Number of children	0.2	1.2	*NS*
All other racial/ethnic groups	0.4	1.5	*NS*
Black and foreign-born	1.7	5.6	**
Black and U.S.-born	0.9	2.5	*
Hispanic and U.S.-born	0.4	1.5	*NS*
Hispanic and foreign-born (excluded category)	--	--	--
Frequency of support from friends/family	0.1	1.1	*
$\chi^2(14, N = 383)$	239.8***		
R^2	.624		

*$p < .05$, ** $p < .01$. or *** $p < .001$.

The factors that were not significant predictors of use of childcare included the mother having a high school diploma or GED or having higher education, currently married or in a relationship with a partner, having more children, living in the Glades, and having a family yearly income at or below the poverty level in the previous year. Thus, except for the factor of living in the Glades, these results are similar to those in year 2.

Additional bivariate analyses suggest that different types of childcare arrangements are associated with a number of maternal characteristics, including race/ethnicity, nativity, education, employment, and income (see Tables 37 and 38). Among Black mothers, a third (33%) used center care, and 31 percent had a relative who took care of their children. Among Hispanic mothers, a third (34%) relied on a friend or neighbor to care for their children, and one-fourth (25%) used relative care. Foreign-born mothers were much more likely to use care by friends or neighbors than U.S.-born mothers, whereas U.S.-born mothers were more likely to use center care and then relative care, a finding that also emerged in the analysis of qualitative data.

There were no differences in the use of center care by nativity; about a third of both native-born and U.S.-born mothers used center care (see Table 37). This result is a change from the previous year when native mothers were much more likely to use center care than foreign-born mothers. It also differs somewhat from other research findings suggesting racial/ethnic differences in participation in center care (Denton & Macartney, 2007; Lippman et al., 2008; Fuller, Holloway, & Liang, 1996; Hirshberg, Huang, & Fuller, 2005; Kinukawa, Guzman, & Lippman, 2004; Lawrence & Kreader, 2005; Liang, Fuller, & Singer, 2000) and suggests that such differences may be explained by other sociodemographic characteristics, the age of the child, and the availability, cost, and quality of care in different regions of the country.[41]

Table 37. Nonparental Childcare Arrangements for Focal Child at Year 3 by Race/Ethnicity and Nativity[a]

Childcare Arrangement	Mothers (*n* = 205)	Race/Ethnicity (%)			Nativity (%)	
		Black (*n* = 105)	Hispanic (*n* = 79)	White/ Other (*n* = 21)	Foreign-born (*n* = 92)	U.S.-born (*n* = 113)
Childcare center/Head Start/Pre-K	33	33	29	48	33	34
Relative	29	31	25	33	25	33
Friend/neighbor	19	10	34	5***	34	7***
Family childcare	12	16	6	10	1	20***
Other/someone else	1	0	1	0	1	0
Multiple arrangements	7	10	5	0	5	7

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
Chi-square tests indicated differences are statistically significant at *$p < .05$, **$p < .01$, or ***$p < .001$.

As shown in Table 38, there were additional variations in the types of childcare arrangements used when mothers were grouped by education level, employment, or their income-to-need ratio. Mothers who have graduated from high school were more likely to use family childcare (16% versus 6%) and less likely to use care by friends or neighbors (13% versus 29%) than mothers who have not graduated from high school.

[41] According to a recent Child Trends report (www.childtrends.org), nationally, 53 percent of children ages 0-4 living in a low-income family were in nonparental care in 2003, but the use of childcare by low-income families varied from state to state.

Table 38. Nonparental Childcare Arrangements for Focal Child at Year 3 by Maternal Education, Employment, and Income[a]

Childcare Arrangement	Mothers (*n* = 205)	Education (%)		Employment (%)		Income-to-Need Ratio (%)	
		Not H.S. graduate (*n* = 86)	H.S. graduate (*n* = 119)	Not working (*n* = 35)	Working (*n* = 170)	At/below poverty (*n* = 84)	Above poverty (*n* = 98)
Childcare center/Head Start/Pre-K	33	31	35	56	28**	42	25*
Relative	29	28	29	20	31	24	34
Friend/neighbor	19	29	13**	0	23**	19	19
Family childcare	12	6	16*	17	11	9	15
Other/someone else	1	1	0	3	0	1	0
Multiple arrangements	7	5	8	0	8	7	7

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
Chi-square tests indicated differences are statistically significant at *$p < .05$, ** $p < .01$, or *** $p < .001$.

As Table 38 indicates, working mothers were more likely than mothers who were not working to use care by relatives (31% versus 20%) and friends or neighbors (23% versus 0%) and less likely to have their children in a childcare center, Head Start program, or pre-kindergarten (28% versus 56%). Likewise, mothers whose family incomes were at or below the poverty level were more likely than mothers with higher family incomes to use center-based care (41% versus 25%), a statistically significant difference. Mothers whose family incomes were above the poverty level, on the other hand, tended to use family childcare or relative care more than mothers with incomes below the poverty level.

We attribute these differences in types of childcare arrangements to a variety of factors, but one important factor is cost. For example, as we report below, the survey data indicate that use of center care, in particular, is related to having a childcare subsidy through Family Central. Of those mothers who received a childcare subsidy, almost two-thirds have the focal child enrolled in a childcare center, whereas less than one-fifth (17%) of mothers who do not have a childcare subsidy have their child in center care.

This finding is supported by the qualitative data. Many of the working mothers in the qualitative study noted the incongruence between their wages and the cost of childcare; they frequently cited cost as the main barrier to using center care. As Tracey, a 19-year-old mother with two children, put it, "that's my entire paycheck every two weeks," when explaining why she split-shift childcare with her partner instead of using a childcare center for her children. Teresa, an immigrant mother of two children, explained her decision not to put her child in center care similarly: "It was $200 [a week] that I earned, but, imagine, now I'd have to pay $80 or $100 for the girl for day care. And what can I do? [What I have left] would be very little." Although some of these mothers were on a waiting list for a subsidy, others reported not being eligible for one. In order to defray the cost of childcare, these working mothers used relative care or tried to arrange to work a schedule with opposite hours to those of their partners.

Costs of Preschool Childcare

When asked if they pay for their childcare, more than two-thirds (70%) of the mothers using childcare reported that they pay all or some of their children's childcare costs. Among the 30 percent of mothers who reported not paying for childcare, about a third did not pay because they received a childcare subsidy through Family Central or received financial assistance from a social service agency, relative, or other individual. Most of the remaining mothers who did not pay for childcare were mothers who reported placing their children in the care of relatives or friends. The qualitative data suggest these mothers may pay indirectly for this kind of care: for example, mothers talked about paying their mother or a sister $100 on an occasional basis or giving her money for gas, bus fare, or food in exchange for caring for their children.

The amounts mothers paid for childcare on a regular basis ranged from as little as $5 per week to as much as $540 per week; this range was the same as that reported in the second year.[42] The average weekly cost of childcare reported by mothers was $68. Based on these figures, we estimate that families using childcare spend from $20 to $2,160 per month for all children in care. Although these monthly cost estimates are not adjusted according to the numbers of hours per week children are in care, most children were in care on a full-time basis. The monthly average of childcare costs reported by mothers in the third year was approximately $270, up from $255 in the previous year. To obtain a rough estimate of the proportion of family income these mothers spent on childcare, we calculated the percentage of the midpoint of the family's reported income range for the previous year spent on childcare. Based on this calculation, the study families spend approximately 19 percent of their yearly income on childcare.

Almost half (49%) of the mothers using childcare reported receiving some financial assistance to help pay for that care. Less than a third (30%) of the mothers using childcare in the third year reported having a childcare subsidy through Family Central; a little fewer than half of these mothers reported having a childcare subsidy in year 2 as well. An additional 13 percent of mothers using childcare in year 3 obtained financial help from a social service agency. A small percentage (6%) said they received help from an individual, such as a friend or relative; only two mothers (1%) reported receiving assistance with childcare expenses from an employer.

Again, this financial assistance was linked to the type of childcare arrangement mothers provided for the focal child. As shown in Table 39, mothers who received a subsidy were much more likely to have their child in a childcare center, Head Start, or pre-kindergarten program (75%) than mothers who did not receive a subsidy (17%). More than two-thirds (69%) of mothers not using a subsidy paid friends or relatives to care for their children (69%) in contrast to only 8 percent of mothers who received a subsidy.

[42] Although the amount of $540 per week seems very high, this respondent was a mother who works 50 hours a week, whose husband also works, and who reported an income between $20,000 and $39,999. She also seemed quite clear that she spends this much for care for her child. Interviewers reported that mothers sometimes had difficulty figuring the amount they pay for childcare, and some of the figures reported for childcare seemed high in relation to household incomes. At the same time, although estimates vary, studies indicate that low-income families spend a greater proportion—20 percent or more—of their income on childcare than families with higher incomes (e.g., Chase et al., 2005; Henly & Lyons, 2000; Koppelman, 2002).

Table 39. Characteristics of Mothers Receiving and Not Receiving Subsidy for Childcare in Year 3[a]

Characteristic	All Mothers Using Childcare (*n* = 216)	Mothers with Subsidy (*n* = 65)	Mothers without Subsidy[b] (*n* = 151)
Age of mother			
Mean age (*SD*)	27.1 (*6.1*)	26.1 (*5.5*)	27.6 (*6.4*)
Age range	17-46	17-42	17-46
Number of children (%)* **			
One	36	16	45
Two	36	44	32
Three or more	29	41	23
Mean number of children**	2.1 (*1.2*)	2.4 (*1.2*)	1.9 (*1.2*)
Mother's race (%)			
Hispanic	40	31	44
Black, not Hispanic	51	57	48
White/other[c]	10	12	9
Mother's nativity (%)**			
U.S.-born	53	68	46
Mother's education (%)			
Less than high school diploma/GED	43	45	42
High school graduate	25	31	23
Post high school education	32	25	35
Mother's employment (%)* **			
Employed full- or part-time	79	63	85
Mother's school status (%)			
In school full- or part-time	16	15	16
Income-to-need ratio (%)**			
Ratio at or below poverty threshold	46	62	39
Income supports received (%)			
WIC	50	59	46
Food Stamps***	32	54	22
SSI	8	6	9
TANF*	4	9	2
Rent voucher program*	3	8	1
UI*	1	5	0
Service use index[d] * **			
Mean services (*SD*)	3.3 *(2.1)*	4.8 *(1.9)*	2.6 *(1.7)*
Service range (0-14)	0-10	2-10	0-9
Childcare for focal child (%) *(n* = 205) * **			
Childcare center/Head Start/Pre-K	33	75	17
Relative	29	--	42
Friend/neighbor	19	--	27
Family childcare	12	25	8

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Some (18%) of the mothers in this group reported receiving help with childcare costs from relatives or another source.
[c] "Other" includes mothers who self-identified as being White, Asian, American Indian, multiracial, and other.
[d] The service use index is the mean number of fourteen service areas used in the previous year, such as health care, food, dental care, childcare assistance, and employment.. These service areas will be discussed in a later chapter.
Chi-square tests indicated differences between mothers with and without childcare subsidies are statistically significant at *$p \leq .05$, ** $p \leq .01$. or *** $p \leq .001$.

Table 39 also shows that there were socioeconomic and demographic differences between the group of study mothers who received a subsidy to assist with childcare costs during the previous year and those who did not. For example, as might be expected, mothers using subsidies were more likely to have an income-to-need ratio at or below the poverty level (62% versus 39%). They also were less likely to be employed at the time of the third interview than mothers who did not receive subsidies (63% versus 85%). In addition, mothers who reported receiving a subsidy were significantly more likely to be high school graduates, to be U.S.-born, and to have more children than mothers who did not use subsidies.

Service use was another characteristic that distinguished the two groups of mothers. Mothers who received a subsidy for childcare were more likely to use other income supports and services than mothers who did not receive a subsidy. Although these results are only descriptive, they are generally consistent with other studies that report higher use of childcare subsidies among mothers using services such as TANF and food stamps as well as differences by maternal education, race/ethnicity, and age and number of children (e.g., Herbst, 2008; Lee et al., 2004; Lowe & Weisner, 2004; Shlay et al., 2004).

Childcare Quality and Satisfaction with Childcare

There is considerable evidence that the quality of care makes a difference in children's development and readiness for school (Burchinal et al., 2002; Howes, 1997; Howes & Smith, 1995; NICHD Early Childcare Research Network, 2000, 2007; Pianta et al., 2002). This is particularly true for young children from families with limited economic resources or other challenges (Karp, 2006). Thus, in this study, it will be important to examine the impact of childcare experiences and the type and quality of childcare on children's outcomes. The primary source of information on childcare quality, other than a measure of mothers' general satisfaction with their childcare arrangements, is assessment information for childcare centers and family childcare participating in the Palm Beach County Early Childhood Quality Improvement System (QIS). Mothers who used formal childcare arrangements were asked to give the name of the childcare center or individual caregiver in an effort to determine how many children were receiving care from providers participating in the QIS. Mothers named eighty different centers and homes as the locations of childcare for 138 children; thirteen (16%) were names of providers currently in the QIS. Of the 138 children, 31 (22%) were served by these thirteen QIS sites. In future years of the study, when the percentage of study children in formal childcare settings is likely to increase, we hope to develop a measure of childcare quality based on assessment information and to examine its relationship to child outcomes.

In addition, the survey also asked mothers using childcare how satisfied they were with their childcare arrangements. Over three-fourths (80%) of the sample said they were "very satisfied" with their care arrangements overall, an increase from 68 percent in the previous year. Seventeen percent were "somewhat satisfied," and just 3 percent said they were either "very dissatisfied" or "somewhat dissatisfied" with their childcare. A smaller proportion of mothers relying on relative care (65%) were "very satisfied" with that care compared with mothers using other forms of care (80% to 88%). This may point to one explanation for the slight decline in use of relative care in general and increases in other forms of care, as shown in Table 38.

In general, mothers in the qualitative study sample spoke favorably about the care provided by relatives—and some mothers were more likely to entrust the care of their children to a relative than to someone unknown even as their children grew older. On the other hand, a few mothers talked about the difficulty of patching together childcare from different members of their families. Some mothers also commented on their children's needs for socialization and learning in a structured environment with other children. Sandra, a mother of one child, said: "He [currently] stays with my mom, [but] I'm already [getting ready] to put him in school. That was one thing I always wanted to do was to put him in school so he'll learn to get along with other kids instead of being under mommy all the time."

School-Age Childcare and Activities

A total of 152 mothers, or 39 percent of the study families, had school-age children in year 3. Fifty-one mothers, or one-third of this group, reported that their school-age children were involved in activities or childcare after school. The amount of time these children spent in afterschool activities ranged from 1 to 48 hours per week, with an average of 13 hours per week. A majority (75%) of the children engaged in afterschool programs and activities participated on a regular basis, that is, five days per week. One-third of the group of mothers with school-age children also reported that their older children participated in organized care or programs during the summer. In more than three-fourths of the cases, school-age children who are in structured care or programs during the school year also participate in summer activities.[43]

As with mothers' use of preschool childcare arrangements, bivariate analyses indicated use of afterschool activities differed by a variety of sociodemographic and family circumstances. For example, mothers living in the Glades (58%) were more likely than mothers living in the non-Glades TGAs (29%) or outside the TGAs (29%) to have their school-age children involved in formal afterschool activities ($\chi^2 = 7.85$, $p < .05$). Foreign-born mothers (21%) were less likely to have children in afterschool activities than native-born mothers (53%) ($\chi^2 = 17.01$, $p < .001$); similarly, mothers who identified themselves as Hispanic (22%) were less likely than Black mothers (54%) or other mothers (47%) to have children in afterschool activities ($\chi^2 = 17.99$, $p < .001$). In addition, working mothers (49%) were more likely than non-working mothers (21%) to have their children in afterschool activities ($\chi^2 = 12.38$, $p < .001$), as were mothers who reported having a childcare subsidy (68%) compared with those who did not have one (44%) ($\chi^2 = 4.07$, $p < .05$).

Because afterschool programs typically are characterized by more than one type of activity, mothers were allowed to give multiple responses when describing their children's afterschool activities. Half (50%) of mothers with school-age children in afterschool programs mentioned at least two different types when describing their activities. As shown in Table 40, mothers reported the most frequent types of activities were educational, recreation, and sports programs.

[43] National estimates of participation in afterschool programs indicate variations as a function of age of child, race/ethnicity, family income, and maternal employment and education. Overall, in 2005, 43 percent of elementary school children in grades kindergarten through 8th grade participated in at least one afterschool activity, with higher participation among students from nonpoor families (56%) than poor families (22%) (NCES, 2007).

Table 40. Types of Afterschool Activities and Programs for 85 Children

Type of Program/Activity	Frequency of Mention[a]	% Activities (*n* = 178)	% Children (*n* = 85)
Education	65	35	71
Recreation	40	23	47
Sports	26	15	31
Childcare	23	13	27
Arts or crafts	21	12	25
Other (not specified)	3	2	4
Total	173		

[a] Frequency of mention refers to number of different types of afterschool activities reported by 51 mothers for 85 children. Multiple responses were allowed for each child.

All mothers with school-age children, regardless of whether their children were spending time at home or in an afterschool program, were asked about their satisfaction with afterschool and summer care arrangements. When asked how satisfied they were with afterschool arrangements for their school-age children, a majority (73%) responded that they were "very satisfied" and another 22 percent were "somewhat satisfied." Almost all (92%) responded that opportunities for afterschool activities for their children were "adequate." Overall, mothers were a little more satisfied with summer activities for their school-age children than they were with afterschool activities. More than two-thirds (80%) said they were "very satisfied" and 20 percent said they were "somewhat satisfied" with their school-age children's summer activities. At the same time, most (90%) of the sample also said opportunities for summer activities were "adequate" (versus "not adequate").

Although the qualitative interviews focused more on preschool children in the sample families, mothers with older children occasionally mentioned their children's school experiences and afterschool activities. Immigrant mothers with limited English skills particularly commented on the importance of homework help and activities to support their children's language learning. When Teresa and her husband came with their son from Honduras a few years ago, he was enrolled in an afterschool language program at the Beacon Center his first year, which included homework assistance and other activities. She said that the program had helped him greatly. However, he was not allowed to continue in the program the second year, perhaps because he was judged to have made sufficient progress the first year not to need it. However, Teresa reported that her son struggles with schoolwork and gets low grades in language-based tasks although he does well in math. When she was asked by the interviewer if she reads with her son, Teresa responded that she reads less with her son than with her young daughter, explaining "because imagine with my language, that I don't know English, to help him with his homework or whatever would be really difficult."

Emerging Themes: Factors that Influence Childcare Use

> *If they go to the day care they can, you know, do some ABC's or do some work like that. That's my main focus—to try to educate them. 'Cause if they stay in here they're not gettin' educated. They'll just be behind by the time they go to school. So I really want them to go in day care.*
>
> ~Michelle, age 23, unmarried mother of two

As discussed above, the survey data suggest that mothers' increased use of formal childcare arrangements in the second and third years of the study was driven largely by their return or entry into the labor market. Maternal employment was the most significant predictor of childcare use. The qualitative data suggest several other factors, in addition to maternal employment, that shape mothers' decisions about the use of childcare. One is the greater availability of formal childcare options for children 3 years and older versus those for infants and toddlers and, correspondingly, mothers' growing knowledge about the options in their communities. In addition, as children become more communicative, more self-sufficient, and more in control of their behavior with age, mothers become more comfortable with the idea of nonparental childcare and begin to recognize the importance of experiences with other children and adults for their cognitive and social development.

As with other services, the various factors influencing childcare choices are interconnected and cannot be easily examined separately. These factors come together in different combinations that are inherently linked to each family's ecological circumstances; these factors also may change over time in response to change in families' ecology. Moreover, childcare decisions cannot be understood apart from parenting practices. When mothers in the study spoke about their childcare preferences and choices, they also expressed their values and beliefs about raising their children. Thus, analysis of qualitative data suggests that mothers' decisions about childcare are influenced by a variety of individual, provider, program, and neighborhood factors. Personal financial and social resources; work status and schedule; parents' values and beliefs; knowledge and choice of services; health, age, and behavior of the child; and family support were the main factors that appear to influence mothers' childcare preferences and use at the individual level. Factors at the provider, program, and neighborhood level typically emerged when mothers talked about their experiences with the childcare subsidy system and specific childcare programs. The major themes at these levels included program quality, cost and availability, eligibility rules, waiting list, and community resources (e.g., transportation).

For example, when Carla described the childcare decisions she made for her young daughter, Maria, she mentioned several reasons for her decisions—financial resources, social support, the availability and cost of childcare, and her beliefs and values. When Carla first went back to work, she and her husband, Diego, decided to place their 21-month-old daughter in a day care center rather than with a neighborhood caregiver. They believed that the day care center would provide Maria with more learning opportunities: "[At the day care center] they learn even more. They start to draw/scribble with crayons. They learn more there in day care, I think." In addition, Carla's aunt had recommended the day care center and helped with the application forms. Carla also could rely on her aunt to drop Maria off at the day care in the morning, because Carla needed to leave for work before the day care opened.

Carla, however, was concerned about the cost of this childcare arrangement and the fact that Maria was often sick. She said she would prefer to stay home with Maria, but extra income was needed. Six months later, Carla told us she could no longer afford the $160 childcare fee on a $250 per week salary and had switched Maria to a neighborhood caregiver. With the new arrangement, Carla was paying only $60 a week. Carla, nonetheless, had not given up on providing a better educational experience for Maria. She applied for a Head Start program in her community and was placed on a waiting list. She is hoping to enroll Maria next year.[44] For Carla, the Head Start program will address both the cost and the educational issues simultaneously: "[With Head Start], it seems like no one doesn't have to pay. They give them food, everything…I liked it because I saw that they had the kids doing activities, and all that I like. Because at home, a kid is watching television all day. That isn't good."

Although the individual factors influencing childcare preferences and use vary from one family to another, several themes dominated mothers' narratives on childcare: balancing work and the needs of children; the cost, stability, and quality of childcare; the child's age and readiness for nonparental care; and parental knowledge, beliefs, and attitudes about childcare. These themes, which are illustrated by Carla's story, are examined further below.[45]

Balancing Work and Children's Needs

As Carla's case illustrates, mothers' need to supplement their family income often triggers their childcare decisions and choices. Some mothers, like Carla, are able to meet both their childcare and economic needs, even if it means they cannot afford their preferred care arrangement. These mothers are able to enlist help from their partners, families, or friends; earn enough to pay a provider, secure a childcare subsidy, and/or work a flexible schedule or synchronize their work schedule with that of the available childcare. But other mothers must make difficult choices in arranging affordable childcare and working to meet their family's basic needs. Typically, their childcare decisions conflict with their beliefs about what is best for their children as the arrangement they end up with is rarely their first choice—nor is it always secure. Ivana's experience with obtaining childcare for her toddler so she could return to work speaks well to the inevitable dilemmas inherent in trying to both meet the economic needs of the family and provide a healthy childcare situation for her child (see Box 4).

On the other hand, Cristal, a 23-year-old, unmarried Hispanic mother of four children under the age of 5, was able to go back to work because she could split-shift childcare with her partner, Roberto. She did not work in the first year after the birth of her fourth child. She told us that Roberto had persuaded her to quit her job and to dedicate herself exclusively to the care of their children. However, after six months, Cristal reported she could no longer afford to be a stay-at-home mother and had returned to her former job working from 5 p.m. to 1 a.m. For Cristal, it was important to ensure that her children were not deprived of anything. "So I thought that they might be without something, because I wouldn't like that the children go without anything. I prefer to work so that the children have everything."

[44] If Carla is referring to Head Start, Maria will be eligible after she turns 3.
[45] These themes are very similar to those reported by Lowe and Weisner (2004).

Box 4. Ivana

"Con otras personas, no se le pueden a dar lo que el niño necesita… Quizás no les abraza. Se quedan tirados en la cama o en la cuna. [With other people, they do not give what the child needs…maybe they don't hug them, and they stay lying on the bed or crib]."

When Ivana, a 25-year-old Guatemalan mother of an 18-old-month boy, Miguel, was first interviewed as part of the qualitative study, she talked about feeling pressured to go back to work to supplement the meager income from her partner, Elias, who had a temporary job. Ivana's concern with the family's economic well-being was justified. After paying rent, they could barely buy food or pay other household expenses. Ivana's assessment of her economic situation convinced her she needed to go back to work, but this decision was not easy for her. She would have to entrust Miguel to the care of a childcare provider who she suspected had been neglectful with him in the past, although she hoped that by paying the childcare provider more she could foster better care: "Like a women told me one time if you pay them $75 per week they will take care of them well; if you pay them $50 a week, they will let them cry." Thus, Ivana decided to take a job at a flower-packing factory and give Miguel's former childcare provider another try.

Six months later, Ivana told us that her first day of work was also her last. When, at the end of the day, Elias picked Miguel up at the caregiver's house: "He was injured. He was shaking. He was crying all day. He did not drink. He did not eat." Elias was adamant that Ivana stay at home to take care of Miguel. Ivana told us that his words were the following. "It does not matter if I pay everything; I prefer that our son grows up first." Ivana agreed with his decision: "When you take care of them [your children] yourself, you can change them, feed them, whatever the child needs. But with other people, they can't give what the child needs. Maybe they don't hug them, and they stay lying on the bed or crib."

One year after Ivana's first interview, the financial situation of the family was even more precarious. Believing there are no other childcare options and with Elias facing unemployment, Ivana and Elias are contemplating a return to Guatemala where they at least would have a roof over their heads and be able to work harvesting sugar cane and pay for their basic expenses. This plan was consistent with the views Ivana expressed in her first interview about the country in which it was easier to raise children, Guatemala or the United States: "[In Guatemala, there is] the lack of money. Here [we can] support them, [but] when you have to work, you have to leave your children with other people and they don't take care of them well." Now, a year later, Ivana feels that raising Miguel in Guatemala may be better.

Meanwhile, Elias and Ivana are trying to meet both their childcare and economic needs. They want to move to a place where Ivana can charge to care for other children as well as Miguel. Currently, the family lives at Elias's aunt's house and Ivana is paid $48 a week for caring for the aunt's 8-month-old daughter. Although Ivana is grateful to be able to stay home with her son and earn this extra money, she is overwhelmed by his recent health and child development issues. After Miguel was removed from the care of a neglectful caregiver, he started refusing solids and stopped talking. Ivana has been feeding him breast milk and pureeing fruits and vegetables, hoping he will eat them. Ivana decided to recruit her Guatemalan friend to help with Miguel's health and behavior needs, because, she confessed, "I don't know much about taking care of children." She is now trying to treat Miguel with a Maya traditional home medicine made from herbs, as her friend recommended, which consists of a regimen of "blows" (soplos) of herbal tea in Miguel's face.

The Cost, Stability, and Quality of Care

The cost of childcare was a recurrent theme in mothers' accounts of their childcare arrangements and frequently cited as the main barrier to using center-based care for younger children. Mothers such as Carla, mentioned earlier, said they would wait to put their children in formal care until they were old enough for Head Start or the state-funded pre-kindergarten program, which would provide a high-quality program at no cost. Meanwhile, the cost factor only compounded the difficulty of balancing work, family, and childcare needs and increased the conflicts mothers felt in arranging care for their children. Mothers understood at some level the relationship between cost and quality and the fact that their income was insufficient for the quality of care they wanted for their children. Even Ivana, who said she was not familiar with the concept of day care, humbly told us: "Like a woman told me that if you pay them $75 per week they will take care of them well. If you pay them $50 a week, they will let them cry.**"**

We address the issue of the accessibility of assistance with childcare costs for the study families in a later chapter in this report, so we only touch on it here. But, as reported above, less than one-third of the mothers using childcare in the third year were assisted by a subsidy. Some mothers in the study were not eligible for a subsidy because their family income level was too high, because they had not yet returned to work, or because they had not worked long enough to collect the necessary pay stubs to apply. Others were eligible and had applied for a subsidy but were on a waiting list.

Some mothers found the work requirement just to apply for a subsidy especially difficult. Although Tracy, a young mother of three children, had been employed at a local discount store for a month, it was not long enough to obtain the necessary number of pay stubs to apply for a subsidy. She, her partner, and her mother were juggling their work schedules so that one of them could watch her three children. Childcare was her major concern: "I'm waiting on day care. That's like my main focus right now." Tracy's nonstandard work schedule made childcare assistance difficult to obtain. In order to qualify, Tracy had to be working more than 28 hours per week and able to present six pay stubs, but she could not work without a stable schedule and reliable day care. Six months later, Tracy reported more stability in her childcare situation since she and her partner had managed to save enough to make a deposit on an apartment of their own and were managing with their informal childcare arrangement: "Right now with both of us working opposite schedules, it is not so hectic, so therefore we don't have to worry about [day care] another bill."

Maria, a 36-year-old mother of 2-year-old twins and a 10-year-old, wondered how she could start a job without first arranging for childcare. When she tried to apply for a subsidy through Family Central when the twins were a year old, she was informed she had to be working to be put on the waiting list. "They said that I should be working and take the checks from what I had worked but supposedly to work I need someone to take care of the babies," Maria complained. Six months later, Maria had arranged for a neighborhood caregiver to care for the children while she was working. Still preferring a formal childcare arrangement for the twins, she again applied for a subsidy and this time was placed in a waiting list. Maria also visited a number of childcare centers, but it just confirmed what she already knew: "If I don't have some kind of help, I don't think I can pay for day care."

Maria also talked about the hidden costs of a day care:

> First, you have to pay money to apply.… And then what they charge weekly, if the baby gets sick on Monday, I have to pay the week even if the baby does not go in the whole week. I can't work. So it is a lot of money that they charge.

After 6 months, Maria's neighborhood caregiver could no longer care for the twins. Fortunately, Maria's sister-in-law offered to take care of the twins. Maria is paying her sister-in-law $200 a week. Although Maria continued to express frustration with the cost of childcare ("I have to pay a lot for them"), she feels happy working: "I feel different when I go to work.… I learn things."

Although Maria was pleased to be working and satisfied with her current care arrangement, despite its cost, her story also illustrates another issue for many low-income working mothers—the instability of childcare arrangements. Over a year's time, children of mothers in the qualitative interview sample experienced at least one and often more than one change in their childcare arrangement. Maria's twins experienced at least two different caregivers. As described in the previous chapter, Miriam's twins spent 6 months in a childcare center but then were home again with their parents, with plans to move so that her mother could care for the children. Some mothers had changed their type of childcare arrangement more than once. The difficulty in securing a stable childcare arrangement reflects, in part, the instability of a family's work circumstances and income; at the same time, the lack of stability in childcare also contributes to instability in their work.

Child's Age, Development, and Readiness for Nonparental Care

The health, age, and development of their children were important considerations in mothers' childcare decisions. Although mothers in the qualitative study began talking about out-of-home care around their child's second birthday (sometimes prompted by our interviewers' questions), they often said they planned to wait at least until their children turned 3 before placing them in formal care. Like Tania, who was quoted earlier in this chapter, they believed that to ensure their children were safe and well cared for, they should be placed in nonparental care only when they are sufficiently verbal, in control of their behavior, and fairly independent in terms of self-care. Angelica, a 24-year-old unmarried mother of three children between the ages of 3 months and 5 years, expresses this view in the following excerpt:

> My son went to [preschool] when he could talk, so that he can tell me [what happened]. And I would ask him questions that he can tell me, "What did you do at school? Did anybody say anything? Nobody touch you? Nobody hit you?" "No, no." He can talk. But put like the baby, she still has diapers. I wouldn't want nobody changing my baby's diaper that I didn't know. I'm like that. I don't trust people. I'm very cautious.

Another single mother, Brenda, similarly worried about the safety of nonparental care for her active 2-year-old: "See I got some hyper little boy, see he is very hyper and I don't want

anybody hurting him and shaking him and beating on him. So I would rather [my children] stay with my mama. I don't want no day care."

Mothers also considered 3, and sometimes 2, years to be the age when children began needing educational and social experiences with other children and adults beyond the family.[46] Sandra, a 20-year-old single mother, said she recently enrolled her 2-year-old in a church preschool program in her neighborhood because she believed it would help her son become more independent and provide an opportunity for him to socialize with other children:

> He [currently] stays with my mom, [but] I'm already [getting ready] to put him in school. That was one thing I always wanted to do was to put him in school so he learn to get along with other kids instead of being under mommy all the time.

Ana believed that childcare would be educational for her son but also help him learn to get along with other children and get used to a routine. Although she noted that some parents believe childcare can cause behavior problems in children, she did not think this would happen with her child. She explained:

> [At childcare] they might teach them a little bit more, they learn to be around other kids; because [my child] likes to play a lot with other kids. So, I say, he is going to play there with the other kids. He will get home tired and he won't need to play. And, like there, he has his time to eat, the time to sleep, his time to play outside, so also, he will get used to, like, a routine. Like that so he gets a little more discipline. And then on the other hand, there are kids, I have known a lot that they say, "No, when they are put in day care, they turn really rude, really problematic." So I say, "What if he becomes like that?" [But] he doesn't hit other kids. He is really easy-going.

Parental Goals and Beliefs about Caring for Children

Parents' goals, level of knowledge about childcare, and their beliefs and attitudes about who should care for their children lie beneath all childcare decisions. It is not clear, but perhaps some mothers who talked about the high cost of care also felt some ambivalence about placing their children in a formal childcare setting. Thus, the prohibitive cost of center care was a rationale for them to choose an option that was more comfortable, for example, to stay home a while longer with their child or arrange for a family member to provide childcare. For instance, when Debra began investigating childcare for her 22-month-old son so he could "interact with other kids," the only center she could find that accepted children under 3 was 10 miles away. When she then learned she did not qualify for a childcare subsidy, she decided to continue having her mother and other relatives care for him while she worked. This was a decision based not only on convenience and cost, she explained, but also on the quality of care:

[46] A few mothers in the qualitative sample also made a distinction between childcare and preschool programs, noting that preschools provide a more educational and enriching environment than other childcare settings. Intuitively, these mothers may see the role of caring for a child as their domain and the role of academic teaching as the responsibility of the (pre)school, a view that may influence their childcare decisions.

> Really, you can't too much trust people around here. I have heard about day cares that have your baby hollerin' all day long. And don't change 'em, and some of them hit them. So, that's kind of stoppin' me from puttin' him in school. If I didn't have a choice, then I would have put him in there. But when I already have people I know would guarantee to watch him, then I don't too much worry about it.

Miriam's situation, described in the previous chapter, shows the influence of a parent's belief about who is responsible for childcare in the struggle to balance the needs of children with the need to work. Because Miriam's goal was for her and her partner to care for their children, she tried to obtain a job in real estate with flexible hours. She explained: "I really am trying my hardest not to put them in day care … to have myself and my fiancé raise them. That is my goal." However, her lack of success in the real estate job meant that she had to consider other work, which would not allow her to fulfill her parenting goal: "Yes, I would say we are struggling. The goal was for me to be a stay-at-home mom and for him to provide, and we're realizing that it's not gonna work out no matter how bad we want it."

The foreign-born mothers in the qualitative sample seemed less familiar with the concept of out-of-home-care, which contributed to their reluctance to consider nonparental childcare. Thus, their views and beliefs about childcare did not align with those of native-born mothers, at least during the first 2 years of their children's lives. Gabriela's difficulty in accepting the idea of someone else taking care of her daughter captured the views of many immigrant mothers toward out-of-home care. Gabriela, a 28-year-old married mother with one child, said that only if she had to work would she leave her daughter in day care because "in the U.S., day care is the law of the land" but she would do so with a "heavy heart."[47]

Over time, however, mothers' knowledge of out-of-home childcare seemed to expand. Mothers gained knowledge through their social networks about the concept of nonparental childcare and options in their communities, as Elvia did when her sister-in-law talked about the concept of preschool as a school readiness program. Furthermore, as children grow older and the need for childcare becomes more concrete, mothers seem motivated to seek information about childcare. Carla first learned about the Head Start program because it was mentioned in an application for the Florida KidCare health insurance program. However, she seemed to take more notice of it both when her need for affordable childcare was greater and when a friend mentioned it to her: "They say there is a day care run by the government [The Head Start Program]. Right now, there is no space.… Just this week my aunt's friend told us, and we went, but no [we could not enroll our daughter for the current year]." As with so many new ideas, they also become more at ease with the concept of childcare as it becomes more familiar to them.

Finally, there is also evidence in some of the mothers' narratives of a further distinction made between childcare centers and preschool programs. In these accounts, the educational and enrichment environment in preschool programs sets them apart from other center-based childcare arrangements. As a result, some mothers seemed to have a more favorable perception of

[47] Subsequently, Gabriela began working as an independent distributor of cosmetic products; she was delighted with this form of work because she could bring her daughter with her and did not need to find another childcare arrangement for her.

preschool programs than of childcare centers. Intuitively, these mothers also may see the role of caring for a child as their domain and the role of academic teaching as the domain of a school (preschool). This underlying perception may be another influence on a mother's decision to use childcare and her choice of care.

The qualitative data also pointed to another important theme—which is the contribution of fathers to the decisions about children's care arrangements, especially in immigrant families. Carla, Cristal, and Ivana, mentioned earlier, all represent mothers whose partner or husband voiced opinions about and participated in childcare decisions for their children. Initially, Cristal's partner persuaded her to stay home with the children. However, when it seemed necessary economically for her to return to work, she and Roberto arranged to share childcare so that they did not have to pay for someone else to care for their children. In the case of Ivana, who seemed overwhelmed by her parental responsibilities and economic concerns, it was her husband who determined that their son not suffer from neglectful childcare just so she could work and who insisted she stay home. Carla and her partner, in contrast, agreed that their daughter should attend a childcare center because it would offer more learning opportunities than a neighborhood caregiver.

When foreign-born mothers talked about their childcare arrangements, they often referred to the views of their partners or husbands, which had a substantial influence on their childcare decisions. Another example is Ana, a 24-year-old mother of a toddler, Mathias, who told us that she would only leave Mathias in day care if she had to work. She said that perhaps when Mathias gets older, she will place him in a preschool program or Head Start because "they say [that kids] develop more if you put them like pre-kinder or day care." Although she had discussed with her partner, José, the idea of placing Mathias in a preschool program now, he said it would be better if Ana stayed home with Mathias: "Sometimes [José] says to me that it is okay if I want to [have him in a school or something like that] but that the boy is so little and that it is better if he is here at home, that no one is going to take care of him like me."

There is also evidence that partners of native-born mothers not only provide childcare but also are involved in childcare decision making, although native-born mothers talked less about their role than foreign-born mothers. For example, in the excerpt below, Sandra, who had recently enrolled her 2-year-old in a preschool, conveys the influence of her boyfriend on her decision to do so.

> So I am trying to let him not be under Mommy a lot 'cause he sleeps with me, every time I go out the door he is behind me. When I go to the bathroom he is behind me, if I go into the kitchen he is behind me. I say to myself I got to try to get him out of this 'cause if I wanted to get a job and put him in school it will be so hard because he wouldn't want me to leave him…. My boyfriend always tells me that is why he takes DeAndre to the park. He is like, "He needs to be around other kids and he is always up under you." And every time DeAndre cries, I am always running towards him giving him his cup. And my boyfriend is always telling me, "Every time he cries you always running trying to give him something." So I got to try to break myself out of it and I got to try to break him out of it. I believe I can do it, I believe I can do it.

Summary

More than half (53%) of the mothers in the third year of the study were using nonparental care arrangements for the focal child, motivated largely by their need for childcare as they returned to work. The most frequently reported type of nonparental childcare arrangement for the focal children in the third year was center care, followed by relative care, and care by a friend of neighbor. When mothers were able to exercise some choice in their childcare arrangements, they were influenced by many factors. Their childcare decisions were influenced, in part, by the cost of care and their family's economic resources, information about, availability of, and location of childcare, and access to transportation. They also were influenced by their beliefs and values with regard to using formal childcare in general and the level of quality they desired for their children. Some mothers, especially those who were native-born or who had lived in the United States for a number of years, seemed to be more comfortable with the idea of nonparental childcare in the third year of the study than they had been in the previous 2 years. Their choices were affected by their children's increasing independence and verbal skills, the increasing availability of center programs (e.g., Head Start and preschool) for 3- and 4-year-old children, and their belief that some kinds of childcare will benefit their children socially and educationally.

Along with the growing percentage of working mothers in the interview sample in year 3 and the increasing age of their children, use of childcare continued to expand in year 3, although the changes were not as dramatic as those from year 1 to year 2. Maternal employment continued to be the strongest predictor of childcare use. Other significant factors predicting childcare use were attending school and race/ethnicity, with both U.S.-born and foreign-born Black mothers more likely to use childcare than other groups of mothers. Residing in the Glades, although a significant predictor in the previous year, was no longer significant at year 3. In addition, mothers who reported more frequent support from family or friends were a little more likely to use childcare. Together, these factors explained about 62 percent of the variation in childcare use.

Additional bivariate analyses suggest that different types of childcare arrangements are associated with a number of maternal characteristics, including race/ethnicity, nativity, education, employment, and income. Among Black mothers, a third (33%) used center care, and 31 percent had a relative who took care of their children. Among Hispanic mothers, a third (34%) relied on a friend or neighbor to care for their children, and one-fourth (25%) used relative care. Foreign-born mothers were much more likely to use care by friends or neighbors than U.S.-born mothers, whereas U.S.-born mothers were more likely to use center care and then relative care, a finding that also emerged in the analysis of qualitative data.

There were no differences in the use of center care by nativity; about a third of both native-born and foreign-born mothers used center care. This result is a change from the previous year when native-born mothers were much more likely to use center care than foreign-born mothers. It also differs somewhat from other research findings suggesting racial/ethnic differences in participation in center care (Child Trends, 2004, 2007, 2008; Fuller, Holloway, & Liang, 1996; Hirshberg, Huang, & Fuller, 2005; Lawrence & Kreader, 2005; Liang, Fuller, & Singer, 2000) and suggests that such differences may be explained by other sociodemographic

characteristics, the age of the child, and the availability, cost, and quality of care in different regions of the country.

We attribute these differences in types of childcare arrangements to a variety of factors, but one important factor is cost. For example, as we report below, the survey data indicate that use of center care, in particular, is related to having a childcare subsidy through Family Central. Mothers who received a subsidy were much more likely to have their child in a childcare center, Head Start, or pre-kindergarten program (75%) than mothers who did not receive a subsidy (17%). More than two-thirds (69%) of mothers not using a subsidy paid friends or relatives to care for their children (69%) in contrast to 8 percent of mothers who received a subsidy.

INFORMAL AND COMMUNITY SUPPORT

An underlying assumption of the service system in Palm Beach County is that if families have strong informal and community supports and access to prevention and early intervention services, they are less likely to need more intensive intervention services. Indeed, an extensive body of research documents the benefits of informal and community supports (e.g., Balaji et al., 2007; Teleen, MacMullen, & Martinez-Schallmoser, 2003; Uno, Florsheim, & Uchino, 1998). Mothers with strong social support networks are characterized by healthier prenatal practices, fewer birth complications, and lower incidence of post-partum depression, all of which are implicated in enhanced maternal functioning and child development outcomes. Thus, an important topic of the interview study is the availability and use of various informal and community supports by families in the TGAs. In this section, we focus on the range and quality of social support—including emotional, instrumental, and informational types of support—from family, friends and neighbors, and other community members over the first 3 years of the study.

Informal Support from Family and Friends

Husband or Partner Support

Survey respondents who were either married or in a relationship with someone they considered a partner—287 (74%) of the 390 mothers in the year 3 sample—were asked about the types of support they received from their husbands or partners. As shown in Table 41, almost all of the respondents reported receiving help with money, food, or clothing from their husbands/partners across the 3 years of the study. Marlene, a single mother of one child, told us about her partner: "He is supportive and he is there, and I know if I need anything and he can contribute he is going to. So I don't have any problems with that.… Most of the times her father will get the diapers and the milk and stuff. And if need him to get a prescription he will get it."

Table 41. Types of Husband/Partner Support[a, b]

Type of Support	% Year 1[b] (*n* = 311)	% Year 2[b] (*n* = 302)	% Year 3[b] (*n* = 287)
Some support from husband/partner	99	100	99
Husband/partner helps with money, food, or clothing	95	96	97
Talk to husband/partner about problems or personal things	95	94	98
Husband/partner helps around house with cleaning or repairs	82	84	78
Husband/partner helps with child discipline	77	91	92
Husband/partner shops for food or household items	79	82	86
Husband/partner gives advice on children or household problems	73	76	69
Husband/partner provides other help (e.g., transportation, childcare)	30	25	9
No support from husband/partner	1	0	1
Husband/partner support score[c] (mean, *sd*)	12.2 (*3.9*)	12.2 (*3.4*)	11.3 (*3.4*)

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] Respondents to these questions were mothers who reported that they were married or in a relationship with a partner.
[c] The husband/partner support score is based on the frequency of all individual items.
*Paired sample *t*-tests indicated statistically significant differences at $p < .05$ between the mean husband/partner support score at year 3 vs. years 1 and *2 and* between help with child discipline at year 1 vs. 2 and 3, advice at year 2 vs. 3, and other help at year 2 vs. 3.

Mothers were less likely to report receiving "advice on children or household problems" (76% in year 2 and 69% in year 3) and "other" areas, such as help with childcare and transportation to school and doctor's appointments. We also observed a 6-percent decrease in partner support received in the area of household cleaning or repairs between year 2 (84%) and year 3 (78%).

The above patterns in partner support correspond with fluctuations in the intensity of support reported by respondents (see Table 42). Whereas the percentage of mothers reporting "daily" support with child discipline increased from year 1 (62%) to year 3 (72%), the percentage reporting daily advice from husbands/partners on child rearing and household problems decreased from year 1 (37%) to year 3 (30%). During the same period, the reported incidence of husbands/partners providing support with cleaning or repairs also declined. Sixty-one percent of mothers reported "at least weekly" help around the house in year 1; by year 3, the proportion of participants reporting weekly assistance with cleaning and repairs dropped to 49 percent. Consistent across the three waves, husbands/partners were least likely to perform household tasks and most likely to provide child discipline on a "daily" basis.

Table 42. Frequency of Husband/Partner Support over Time[a]

Type of Support	% Year 1 (*n* = 311)		% Year 2 (*n* = 302)		% Year 3 (*n* = 285)	
	Daily	At least weekly	Daily	At least weekly	Daily	At least weekly
Help with child discipline	62	12	72	15	72	17
Talk about problems	53	31	50	33	46	38
Help with money, food, or clothing	51	33	48	39	50	33
Advice on children or household problems	37	26	35	29	30	26
Help around the house with cleaning or repairs	19	42	22	36	22	27
Shop for food or household items	11	57	6	64	8	65

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."

*Paired sample *t*-tests indicated statistically significant differences at $p < .05$ or less between frequency of help with child discipline at year 1 and year 2, frequency of advice at year 1 and year 3, and help with household chores at year 1 and year 3.

The qualitative data offer additional evidence for the decreasing frequency of household support from husbands and partners. Some mothers talked about receiving help "occasionally" or when they or a child is sick. According to Ana:

> Sometimes on weekends if we don't go anywhere for any reason, and we just stay around here, he will help me around here. He always helps with mopping, but that is all he likes [she laughed]. He doesn't like to wash dishes or anything. He'll help clean the floor.

Maria reported, "When there are occasions when the children are sick, he makes dinner or cleans up the kitchen. Other mothers talked about partner contributions occurring mainly on the weekend when they are not working. Laura, a married mother of two children, said:

> [My husband] helps me sweep or wash the bathroom or if I get up and make

> something for breakfast, he [will] organize the room and helps my daughter make her bed. Usually he helps me like that on the weekend because on the weekdays, I even feel bad for him [because he works hard]. And then they eat and he rests for a while, he bathes and he goes outside to play with the children.

These findings suggest changes in the roles of husbands and partners over time. For example, the decrease in the amount of advice given on children or household problems may be attributable to mothers' changing preferences for alternate sources of advice (e.g., pediatricians, books, and other printed material) or an increase in mothers' experience and confidence as their children become older. The decrease in partners' help with household chores might also reflect the increasing independence of the focal children and mothers having more time to accomplish tasks on their own. For example, although Marlene expressed appreciation for the contributions of her partner when she said, "I know if I need anything and he can contribute, he is going to," she also acknowledged that "I am Miss Independent," suggesting that she would rather not depend on his help.

These trends may also reflect a shift in the roles of husbands and partners as their children progress from infancy to toddlerhood and caregiving or fatherhood takes on new dimensions. For example, we found a significant increase in reported help "at least weekly" from husbands/partners in disciplining children between year 1 (74%) and year 3 (89%). One mother explained:

> Yeah, he wouldn't hold him when he was a baby. He said he was too small. And then when he got a little older and a little bigger, that is when he start coming more onto him. But when he was a baby, he wouldn't hold him that much because he was scared he was going to drop him.

In at least one case, father involvement was tied to confirmation that he was the child's biological father: "Her daddy just got the paternity test back, now he wanna be in her life. He come get her sometimes, spend the day with her." Some mothers also reported that their children respond better to their fathers than their mothers. Ana reported:

> He gets all the toys out [and] leaves them all over. And I tell him to pick things up and he says "huh" [and] shrugs his shoulders. And then with his father, he pays a little more attention to him. His father tells him to pick things up, and sometimes he says no. And [his father] says, "Pick them up," and raises his voice a little. So, he will start to pick them up. But not to me. When I raise my voice, he doesn't pay attention. He makes fun of me.

Despite these changes in the frequency of different kinds of support from their husbands or partners, mothers' reports of their satisfaction with the support they receive from their husbands or partners in the third year were consistent with the satisfaction levels reported in the first two years of the study. More than three-fourths (78%) of the year 3 sample described themselves as "very satisfied," 20 percent were "somewhat satisfied," and just 2 percent were "somewhat or very dissatisfied." Sandra told us:

> I have a boyfriend and he really helps me out 'cause DeAndre's father is not in his life. My boyfriend makes sure he has diapers, clothes, [and] makes sure he has things he needs to eat and milk. So if it wasn't for him, I don't know what I would do.

Mothers were also asked about the quality of the relationship with their husbands or partners. When asked how often their husbands or partners show affection toward them, 65 percent of the sample responded "often," and 34 percent said "sometimes." When asked about the frequency of arguments with their husbands or partners, 79 percent reported that they argue "sometimes," 18 percent said "never," and 3 percent said "often." Qualitative data indicate that when there are conflicts, they center around money and parenting. For example, Denise, an unmarried mother of two toddlers, complained that her partner would not purchase a computer for her even though he had the money:

> I asked him if he could get me a computer. He said he would get it but it will take a month to do it. He does this thing where he will go buy something and spend money and then he's in the red. He calls it a red light. To anybody else or to me he is nowhere near the red. It is just he spent over two hundred dollars and he thinks he is in the red.… He is cheap. That is what is wrong with him because he has the money; like right now he doesn't have to work.… And he just saves it. He thinks he is in the red, and I think he is in the green … green light, green light.

Miriam, who was described earlier in Box 2, acknowledged that she and her partner "just don't see eye to eye on how we're supposed to raise the kids and how life is supposed to be for us. I refuse to compromise a little his way, he refuses to compromise my way." She also expressed firm beliefs about her partner's role in providing for the family:

> I buy diapers, baby wipes, formula, you know. Just kids stuff, 'cause they need it. But I don't buy anything that the house needs. That's not my job. I'm not supposed to provide. That's not how I was brought up. And he'll sit there and complain to me, "You're working now and you're not providing for this family?" I'm like, "I am providing. I'm paying the thousands of dollars you haven't paid my mom in months [for rent]. So, I get what the kids need, and everything else goes to my mom." He's like, "Well, what about this family?"

Family and Friends Support

In addition to husbands and partners, a majority of mothers (93%) reported receiving assistance from family and friends in year 3 (see Table 43). Significantly decreasing percentages of respondents reported that "none" of their friends or family provided support from year 1 (11%) to year 3 (7%) and again from year 2 (10%) to year 3 (7%). According to the mothers, siblings and mothers/stepmothers were the most frequent source of support. Brenda stated: "With my Mama by my side, I will make it. Half of the time my Mama or most of the time my Mama buy my children stuff.… So we will make it, by the grace of the Lord we will make it." More than half of the respondents reported receiving help from siblings (53% to 57%), and almost half of them reported receiving help from mothers or stepmothers (46% to 49%) all 3 years. On the other hand, there was a decrease in reported support from other family members, such as aunts,

uncles, and cousins. The reasons for these changes are not entirely clear but may be tied to the age and development of the child: relatives may tend to be more attentive around the birth of a child and less so as the child gets older. For example, Gabriela, a married mother of one child, told us the following: "No one ever calls, 'How are you?' When I had my daughter, of course, they came to visit, they did the baby shower, but after that, no one, 'How are you? How is your daughter? How is it going with your daughter?'"

Support from non-family members varied slightly over time. Support provided by friends dropped between year 1 (49%) and year 2 (43%) but rebounded in year 3 to its original level (50%). Respondents reporting assistance from neighbors showed a decrease from year 1 (19%) to year 3 (14%), whereas support provided by former husbands/partners showed an increase between year 1 (6%) and year 3 (10%). It should be noted that the proportion of respondents who were either married or partnered decreased from year 1 (80%) to year 3 (74%). Thus, the rise in received support from "former" husbands or partners may reflect the increase in marital or partner separations within the sample families.

Table 43. Family and Friends Support[a]

Person Providing Support	Year 1 % Mothers[b] (*N* = 390)	Year 2 % Mothers[b] (*N* = 390)	Year 3 % Mothers[b] (*N* = 390)
Family member			
Sister/brother	54	53	57
Mother/stepmother	49	49	46
Mother-in-law/father-in-law	30	29	26
Father/stepfather	24	28	26
Grown children and other relatives	26	22	25
Aunt/uncle	30	26	21
Cousin	27	23	18
Grandparent	21	21	18
Non-family member			
Friend	49	43	50
Neighbor	19	16	14
Former husband/partner	6	9	10
Co-worker	7	11	8
Others	3	5	2
No other family or friend support	11	10	7
Family/friend support score[b]	9.4 (*5.3*)	8.5 (*4.8*)	8.3 (*4.0*)

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] The family/friend support score combines items that ask about the frequency with which mothers talk with family or friends listed about problems; receive help with money, food, or clothing; receive help with work around the house or caring for children; receive advice on how to care for children or handle household problems; and receive other types of help.
*Paired sample *t*-tests indicated statistically significant differences at $p < .05$ or less between the mean family/friend support score at year 1 compared with years 2 and 3.

The frequency of support from family and friends also declined over time. In year 1, 39 percent of respondents reported receiving "daily" advice on child rearing or household problems. The following year, 29 percent reported the same frequency of support, and, by year 3, less than

a quarter of mothers (22%) reported "daily" advice from family and friends. Mothers were also less likely to talk to friends/family about personal matters on a "daily" basis. In year 1, 32 percent of respondents reported "daily" support, but by year 3, only 26 percent of the sample reported "daily" support for personal problems. Finally, the number of mothers reporting either annual or no assistance with food, money, and clothing jumped from 39 percent in year 1 to 50 percent of the cohort in year 3. Again, this overall decline in high-frequency support from friends and family might be related, in part, to participants' growing skills and parenting competencies and the progressive independence of the focal children. It also might reflect, for some mothers, a reluctance to ask for help or a lack of confidence in the quality of care friends or relatives might give their children. Although Laura said she was willing to help friends with childcare, she was reluctant to ask them to care for her child even for an hour or two. In her words: "I rarely like to ask for favors. Only [one] woman I ask with trust [to care for my child]. If they ask me for something, it is fine if I can help them." And Marta, who pays her mother to watch her child, stated, "Let me tell you—save money so you can stay home because nobody is going to give your child better care than you."

Table 44. Frequency of Family/Friends Support over Time[a]

Type of Support	Year 1 (n = 346)		Year 2 (n = 351)		Year 3 (n = 365)	
	Daily	At least weekly	Daily	At least weekly	Daily	At least weekly
Advice on children or household problems	39	24	29	23	22	21
Help with housework/childcare	35	21	33	19	29	17
Talk about personal problems	32	29	26	29	25	26
Help with money, food, or clothing	13	15	7	13	4	7

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
*Paired sample t-tests indicated statistically significant differences at $p < .05$ or less between frequency of advice at year 1 and year 2, advice at year 2 and year 3, talk about personal problems at year 1 and year 3, and help with money, etc., at year 1 and year 2, and at year 2 and year 3.

Emerging Themes in Family and Friend Support

The analysis of survey data suggests that the study families use a wide constellation of informal supports. Although a large majority (93%) of mothers report having some kind of informal support, the type and frequency of support varied across families. Almost three-quarters (73%) of the sample reported receiving support from a husband or partner in year 3, although the intensity of partner support differed across couples. About half (46%) of the respondents reported receiving assistance from mothers or stepmothers, and another 50 percent cited the support of friends. Mothers' reports also revealed fluctuations in the type and frequency of support received over time. In the first year, 39 percent of mothers reported "daily" parenting advice from friends and family; by year 3, less than one-quarter (22%) cited the same frequency of support.

Given the variability in reported support, we decided to flesh out the structure of maternal support networks with additional qualitative data. Analysis of the first three waves of interviews indicates that many mothers in the qualitative study develop informal support networks. In this

section, we address the most common forms of informal support provided by friends and family, other than partners and husbands, which are evident in the qualitative data. (In a later report, we will provide an analysis of partner support.)

Mutual support was a dominant theme in the qualitative data. At least thirty mothers—more than half of the qualitative study sample—cited relationships of mutual support, including instances of babysitting swaps, cooperative living, shared meals, assistance with service applications and appointments, and borrowing and lending. These cooperative strategies map onto previous studies documenting the use of social networks among low-income, minority families, which describe strategies such as "swapping" (Stack, 1974), "child-keeping" (Stack, 1974), "doubling up" (Edin, 1997) and cash contributions (Edin, 1997). Like the African American families documented in Stack's landmark study (1974), the social networks of Palm Beach County families function as a mix of welfare and social insurance, bridging immediate gaps in service and improvising a safety net for future needs.

Informal Childcare

Swapping childcare or relying on relatives to provide care was a common strategy employed by mothers in the qualitative sample; at least sixteen mothers discussed this topic. Whether a mother is working or running errands, she frequently relies on her kin and family network as a reliable, cost-effective source of care. As Ana, mother of 2-year-old Jose, said, laughing, about her mother: "She is his grandma, and if she is paid or not, she is going to take care of him." This sentiment was echoed by Janice, a single mother of four children, who described herself as "lucky" to have free babysitting: "[My mother and sisters] will babysit for me all the time. Usually I will throw them like 5 bucks or you know, but they don't ask for it. I am lucky. A lot of people don't have that."

Other mothers cited the quality or individuality of care provided by family and friends. Linda, mother of two children, made the following comment on the love provided by her child's godparent and babysitter: "[She's a] daughter to her.… They love my kids. Them her godkids." Another mother, Marlene, expressed gratitude for the specialized care offered by her mother:

> Having my mother here with her is big help.… I pay her because I know that I will have to pay somebody else and then again she goes above and beyond. And it is worth it, even if I had to put her in another day care, I don't know if she would get the treatments that she needs because there are so many meds that I don't know if they could actually do that in a regular day care.

Although some mothers did not seem to feel obliged to contribute, the majority traded babysitting or offered tokens of appreciation (money, gifts, housecleaning) in exchange for informal care. Several mothers gave "cash contributions" (Edin, 1997). "Sometimes I pay her to watch him 'cause she don't have a job and she is always asking for money." Others, as mentioned above, swapped care: "Raquel, I usually have her kids and she has mine. Like we switch up sometimes." A small number of mothers reported trading housecleaning or shopping favors for childcare: "We go down there and I help my mom clean up her house and that is about it."

Shared Living and Meals

Following babysitting, cooperative domestic arrangements and shared bills and meals were some of the most common exchanges among mothers in the qualitative sample: thirteen mothers talked about these strategies.. The majority organized domestic partnerships with mothers, children, and extended kin and, in some cases, friends or godparents. In these arrangements, extended kin and/or friends share duties and activities typically associated with the American "nuclear family." Cooperation in the household can be as simple as alternating chores, as described by LaToya, "I will cook today, my sister will cook tomorrow," and by Denise, "My grandmother usually does the cooking, my brother takes out the trash, and we all do the dishes," or as complex as alternating care for an elderly relative. For example, Sandra, single mother to 2-year-old DeAndre, reported a more demanding household structure:

> Me and [my sister] take turns with my grandmother [who has Alzheimer's] and my son. When we both have to go to work, she will watch DeAndre for me and then I will watch Grandma for her. To take care of Grandma is like taking care of DeAndre. She can't go into the bathroom or go to the bathroom on her own.… You really have to keep an eye on her because she can get into a lot of stuff.

For some families, domestic arrangements emerged from the volatility of agricultural work. During the high season, families alternated chores when harvesting demanded extremely long workdays. During the low season, a period in which there is little work and even less money, cooperative partnerships eased financial pressures through the pooling of income and other resources. Norma, a single mother of one child, explained:

> When the season's on, me and my mom are working, and [my father's] the one doing the housework (laughs). He's the woman, I guess during that time. Then when we get off the season he be like "Oh, I'm got used to not doing nothing and I wanna be sittin' down."

Leticia, a married mother of eight, reported that her domestic burden is more manageable during the "low season":

> Since he works in the [agriculture], right now he is taking unemployment.… It's better, because when we get home sometimes he has made something to eat or has done something. And when he isn't [home], well, we [mother and daughter] have to do it all ourselves.

Cooperative domestic arrangements, including chores and meal preparation, are not limited to single households. In many cases, separate households shared the household activities and tasks typically associated with the "nuclear family." For example, Tracy described how her family members living in separate residences come together to share food stamps and shopping:

> So we like basically spend it up and my sister she gets food stamps so she gets hers before I get mine, so she usually helps us and then whatever we have left we will help her. Or she will go to the grocery store with us and we mainly just get

> what she needs or what everybody needs at one time. So we usually help each other.

Another mother, Brenda, said she lived separately from her mother but shared food stamps and daily tasks with her mother:

> Basically, I be at my Mom's house all day with the children, we play and stuff.… I put two hundred [food stamps] in here for me and Jamel and I go down there and spend the rest with my children and put all the rest in my Mom's house for the other two. So we are trying to make it around here.

In many ways, the "household" exemplified by some of the study families is not a fixed space but a network of mutually supportive relationships, which may include temporary living quarters (e.g., a couch to sleep on) in times of need. Mothers and fathers may live alternately with parents and partners; children may take turns living with grandmothers and mothers. For many of these families, economic instability, in the form of a lost job, pregnancy, or poor housing conditions is a precursor to rearranging households. For example, Tracy, when she was expecting her second child, returned to her grandmother's apartment to reduce costs. Subsequently, she and her partner had saved up enough money to move into an apartment. A pest infestation in the new apartment, however, stalled their plans, and the couple and their children were forced to stay with relatives.

Brenda illustrated a similar pattern of alternating households. In the first two qualitative interviews, Brenda lived primarily with her partner, Bob, and one child in one household, while her two older children lived with her mother. On occasions, however, she felt compelled to live with her mother: "Bob sometimes be on his spells. He argues for anything, name calls. When he argues, I just leave and go to my Mom's house. I try not to be in his way 'cause I know how he is." By the third interview, Brenda had left Bob and joined her children, grandmother, nieces and nephews, and her mother in their trailer. Bob, out of economic necessity, had left for Georgia to work in the fields: "He went out of town, he went to Georgia … but I didn't have no money 'cause I don't get no income. With my mama by my side, I will make it."

Several mothers also described domestic arrangements in which children are temporarily housed with relatives. These arrangements often stem from childcare complications or financial necessity. Denise, mother of two, had her children in California with their grandmother; she used this period to search for a job and childcare. In her words, "I was trying to stay here and still get a job that is flexible so that when they come back I will be able to work it." Lariza, mother of four, also lives separately from her child, "and what he gives me is what I send to my daughter in Guatemala." Lariza desperately wanted to bring her daughter to America, but she did not have the money or legal power to do so.

As demonstrated by the above families, support networks may extend across states and international borders. But foreign-born mothers, with primary ties in distant lands, often formed different support networks than their U.S.-born peers. Although immigrant mothers in the sample reported equivalent amounts of social support overall, their domestic networks were more likely to consist of distant kin, neighbors, and co-workers. For example, Anna and her

partner, originally from Guatemala, shared housing with four male relatives (brother, cousin, brothers-in-law), in addition to their four children. Another Guatemalan mother, Cristal, shared living quarters with her husband, four children, two male relatives, and someone she is "helping out": "And well, I offered her [friend] to stay in my house to see what I could do because my brother works in the same job and so I helped her.… She does not have a family or a husband. She does not have anything."

Immigrant families "double up" for multiple reasons. Not only can it ease the transition to a foreign country, but it can also serve as an instrument to meet daily needs. For these families, work (typically in agriculture or construction) is often unpredictable and wages are rarely sufficient. "Doubling up" was essential to paying bills and keeping food on the table. Anna explained:

> They aren't used to so much time without jobs, or without money, so they get really worried about where they are going to get it. The rent is due or the light bill comes, the phone bill … it is great that there are so many of us, because between all of us we share. We say, "How much is it?" and each one puts in their share.

Another mother, Silvia, shared living costs with four friends (including a distant cousin and a husband of a cousin) and cooked hot lunches in exchange for payment. In this way, Silvia remained the primary caregiver for her child, while her roommates saved time and money on food preparation. In her words: "Well, it is like, how do you say it? We are organized in everything … so that not only one person has to do it."

If an immigrant family or "co-op" was struck by financial misfortune, they were also able to tap into extended social networks for emergency loans. Immigrants have few choices when financial disaster strikes; credit cards and bank loans are usually inaccessible and, for some, the benefits of social programs rarely outweigh what they perceive as the risks of application. Instead, immigrants must turn to extended kin, both in the United States and abroad, for emergency loans. All six of the mothers who talked specifically about informal borrowing and lending practices were foreign-born; most of them described moderate scale loans to cover the costs of health care, legal assistance, or housing. Maria reported that her Cuban relatives were instrumental in securing their home: "Someone was willing to give us a loan if we did not have enough to pay the house. They also signed." Another mother, Leticia, cited assistance with housing from her aunt: "Now, my aunt is in Mexico and she owns this apartment; she told us it was okay. She could wait for us [to pay the rent]. She already made the payment because she has money." Finally, Laura, married mother of two, describes a situation in which they borrowed money from one relative to offset the loan made to another: "In November, I think, we did not have money to pay the rent because my husband's mother got sick in Mexico and they had to operate on her, we sent them money and everything. And my brother-in-law helped us. He lent us money."

Ethnic Differences in Mutual Support

As suggested above, foreign-born and U.S.-born mothers report similar amounts of support overall. However, Spanish-speaking families in the qualitative sample were more likely to mention borrowing and lending practices among relatives—as opposed to cash contributions—

and assistance with appointments and service applications than were African American mothers. Babysitting exchanges are also slightly different for Hispanic mothers. These immigrant mothers were less likely to pay for informal childcare and more likely to use care for shorter periods. Abigail, a married mother of one child, explained: "At times, if it is a lot of time, [my mom] will accept [some money], but if not, she won't accept it. [And] I don't charge her.**"** Several immigrant mothers also expressed hesitation about accepting support, as indicated by the following quotes: "We are not like that"; "I rarely like to ask for favors"; or "… because we really don't like to ask for money, when we are at the point that we are really, really, really, really don't have another way, that's when."

Immigrant families in our sample also were more likely to practice the strategy of "doubling up" (Edin, 1997) or pooling the costs of living. Many families share living space with cousins, nephews, and friends. They also reported exchanging financial support with family members in their country of origin. Although several families reported sending money to relatives back home, the most common form of exchange is to borrow and lend money or exchange gifts, as was the case with the help Laura, Maria, and Leticia received with housing expenses. Marta also noted: "When some family member of theirs or of ours comes from Cuba, they always give them a gift. When we do something, when we have a dinner here, or something they come or we go." Other mothers describe the benefits of having relatives visit. Juanita, a married mother of two children, said with a smile: "[My sister] just came. I feel good because when I go to the clinic, she takes care of my kids."

Conflicts in Social Networks

Although the informal support described above may offer security and stability to many families, it is not without its challenges. We also found in the qualitative data evidence of conflicts over childcare, chores, and choices that threaten the provision of support and, in some cases, the relationship itself. Most conflicts within the informal support system revolve around issues of choice and independence and either insufficient support or the perception of unequal support.

For example, although, more often than not, mothers tended to trust family members more than non-family members, some mothers expressed dissatisfaction with the quality of childcare provided by family. Miriam, a single mother to three children, who had to rely upon her ex-boyfriend for babysitting, complained: "And I go to work the next day and come home, and he's drinking again. Obviously, to me he's not making an effort and he thinks that it's okay 'cause he says, 'Well the kids are sleeping. I can drink.'" Ana expressed concern over her mother's ability to juggle illness and childcare when her mother took her child to a doctor's appointment:

> For her to take him out, I didn't feel so secure about it. She isn't in a condition to run after him and follow him. So last Friday, my mom didn't say anything, but she took him to the doctor with her. And just yesterday she told me, I mean she didn't say to me that she was going to the doctor. I told her, "You should have told me. There are other people who could have watched him for a little bit.… When you are going to have an appointment or something like that, let me know." Because it is dangerous.

In addition, the qualitative data also indicate that complex living arrangements, including multiple family households and special needs situations, can be difficult to sustain over time. For example, in an earlier excerpt, we described Sandra's arrangement with her sister that allowed them to jointly take care of her grandmother, who has Alzheimer's disease, and her son. She acknowledged in the first qualitative interview that despite sharing the responsibility with her sister, it was a difficult situation: "It be hard; and me and my sister will take turns watching each other. … It be kind of hard." Indeed, this arrangement proved unmanageable over time. By the third interview, Sandra and her child, DeAndre, had relocated to the godparent's home and Sandra's mother had assumed the role of primary caregiver.

Community Support

"Community" encompasses a variety of professionals with whom respondents may have contact – everyone from medical personnel, school personnel, social service personnel, and members of the clergy. Overall, respondents are reporting higher levels of community support as time progresses. Forty-two percent of the respondents reported support from someone in the community in year 1, 44 percent in year 2, and 56 percent in year 3 (see Table 45). Doctors, for example, provided significantly more support to the respondents in year 3 (29%) compared with years 1 or 2 (13%). This may be due to the rise in special needs diagnoses among the focal children. In year 1, just 9 percent of respondents reported their child's special needs; by year 3, the number of children reported with special needs doubled to 18 percent of all focal children. Or, it may reflect an increasing reliance on pediatricians and other health care providers for parenting and other advice that was obtained formerly from other sources.

Table 45. Community Support[a]

Provider of Support	Year 1 % Mothers (*N* = 390)	Year 2 % Mothers (*N* = 390)	Year 3 % Mothers (*N* = 390)
Some community support	**42**	**44**	**56**
Doctor	13	13	29
Someone from a place of worship	--[b]	17	18
Caseworker	15	11	16
Child's teacher	6	11	15
Nurse or other medical person	14	10	13
Childcare center staff	2	8	11
Other school staff (e.g., social worker, guidance counselor)	6	5	7
Information hot line	1	4	7
Counselor/therapist	3	4	6
Family support worker	14	4	5
Community service organization	1	2	3
Other	2	1	1
No community support	**58**	**57**	**44**
Community support score[c]	.77 (*1.2*)	.91 (*1.5*)	1.3 (*1.6*)

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] This item was not included in the year 1 survey.

[c] Community support score is a mean of all of the items for each year.
*Paired sample *t*-tests indicated statistically significant differences at $p < .05$ or less between the mean community support score at year 1 and year 2 and between the scores at year 2 and year 3.

The support that respondents received from school teachers and childcare center staff also increased significantly over the 3 years—perhaps reflecting the increase in use of childcare over time. In year 1, just 6 percent of the respondents mentioned support from their children's school teachers. By the third year, 15 percent of the respondents noted such support. Likewise, just 2 percent of respondents reported receiving support from childcare staff in year 1. In years 2 and 3, the number of respondents reporting childcare staff support increased to 8 percent and 11 percent, respectively. The rise in teacher and childcare staff support coincided with the increased number of children currently in school and childcare. For example, in year 1 interviews, very few (23%) respondents reported childcare services. As time passed and the children matured, more mothers began utilizing childcare services (51% in year 2 and 56% in year 3).

The support received from social service workers fluctuated over time. Although respondents indicated a dip in caseworker support between year 1 and year 2, by the third year, 16 percent of respondents were utilizing such support. The assistance received from family support workers also significantly decreased during the same period; from a high of 14 percent during the first year to 4 percent and 6 percent in years 2 and 3, respectively. The amount of perceived support from counselors increased significantly over time. In year 1, just 3 percent of respondents noted support from counselors, but in year 3, 6 percent noted this support. Another notable increase in support was that received from information help lines. In the first year, just 1 percent of respondents reported receiving help from information help lines, but in the second, 4 percent reported this, and by the third year, 7 percent reported this assistance.

Although there was no change in the percentage of mothers reporting support from a place of worship between year 2 and year 3, mothers did report an increase in attendance at church or another place of worship during this period, with more people attending once or twice a month or weekly in year 3 compared with year 2. Twenty-two percent said they attended "monthly" in year 3 compared with 17 percent in year 2, and 29 percent said they attended "weekly" in year 3 compared with 27 percent in year 2. As in the past, there appears to be a correlation between participation in a place of worship and help received; 63 percent of the year 3 respondents who reported receiving support from "someone from a place or worship" also reported attending church "weekly." Interestingly, sometimes this help may come with a cost. According to Ivana, sometimes food is provided after the church service she attends, "but you have to buy it. [It's] not free. You have to pay so the church can grow. It is like an offering. From the Church you hear the word of God. We have friends there, and the pastor welcomes everyone."

With respect to the kinds of community support families received, mothers tended to report receiving advice on children or household problems somewhat more frequently than concrete support such as help with money, food, or clothing (see Table 46). However, we saw an increase from the previous year in reported help from community members with money, food, or clothing. For example, 16 percent of the sample reported at least "weekly" help with money, food, or clothing, and another 41 percent reported this help "monthly." In the previous year, just 3 percent of the sample reported receiving this help "weekly," and 12 percent "monthly."

Reported help in the form of advice on children or household problems in year 3, however, was relatively unchanged from that in year 2.

Table 46. Frequency of Community Support at Year 3[a]

Type of Support	Frequency (%)				
	Daily	Weekly	Monthly	Annually	Never[b]
Advice on children or household problems	3	13	54	14	16
Help with money, food, or clothing	3	13	41	11	32

[a] Only 162 mothers who reported receiving support responded to the frequency questions.
[b] The "Never" response refers to mothers who reported receiving some types of community support but not the type indicated..

Access to Support

As shown in Table 47, perceptions of access to support fluctuated over time. There was a drop from year 1 to year 2 in the percentage of mothers who said it was "very easy" to get advice on caring for children or taking care of household problems or to get help with housework or childcare; however, the percentages increased in the third year. In addition, there was an overall decline in the third year from the first 2 years in the percentage of mothers who reported that it was "very hard" getting help with housework or childcare (32% in year 2 vs. 21% in year 3) and the percentage who reported that it was "very hard" to talk to someone about things that are very personal or private (33% in year 1, 31% in year 2, and 25% in year 3).

Table 47. Perceptions of Access to Support from All Sources over Time[a, b]

Type of Support	Level of Access (%)		
	Somewhat/ Very Easy	Between Hard and Easy	Somewhat/ Very Hard
Mothers at Year 1 (*N* = 390)			
Get advice on caring for children/handling household problems	73	16	11
Get housework or childcare help	58	16	26
Talk about problems or personal or private things	55	12	33
Mothers at Year 2 (*N* = 390)			
Get advice on caring for children/handling household problems	67	13	20
Get housework or childcare help	55	13	32
Talk about problems or personal or private things	57	12	31
Mothers at Year 3 (*N* = 390)			
Get advice on caring for children/handling household problems	73	15	12
Get housework or childcare help	63	17	21
Talk about problems or personal or private things	60	16	25

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
*Paired sample *t*-tests indicated statistically significant differences at $p < .05$ or less on getting advice on childcare/household problems between years 1 and 2, and years 2 and 3; on getting help with housework/childcare between years 1 and 3 and years 2 and 3; and on talking about problems between years 1 and 2 and years 2 and 3.

Access to Support by TGA

Table 48 shows perceptions of support over time among the TGAs. Every year, respondents in the Glades report finding access to support to be either "very easy" or "somewhat easy" as compared with their counterparts outside of the Glades. Across all3 years, more than three-fourths of respondents in the Glades were significantly more likely to report "very easy" or "somewhat easy" access to getting help with housework or caring for children. At the same time, Glades mothers' reported opportunities to talk to someone about personal or private matters seem to be waning. In year 3, 65 percent of the respondents reported that it was either "very easy" or "somewhat easy" to get this type of support as compared with 74 percent in year 1 and year 2.

One factor in these geographic differences may be that families in the Glades appear to be less mobile (see Chapter 2); thus, even though this area may have more "risk" characteristics in other areas, the level of perceived social support is higher. Because families are not moving and have lived longer in the Glades, mothers may have more family and friends accessible to them as well as more knowledge of community supports and services.

However, as Table 48 suggests, in the non-Glades TGAs, finding someone to talk to about things that are very personal or private is beginning to increase, with 60 percent of the year 3 non-Glades respondents reporting that access to this support was "easy" or "somewhat easy" compared with 53 percent in year 1 and 54 percent in year 2. Another noteworthy increase seen in the non-Glades TGAs is in reference to "help with housework or caring for children." There was a decrease in the ease of access to this type of support between year 1 and year 2, but in year 2, 51 percent of the respondents reported that it was "very" or "somewhat" easy to get support with housework or childcare, and in year 3, 60 percent reported that it was "easy" or "somewhat" easy.

Table 48. Access to Support by TGA over Time[a]

	Access "Very" or "Somewhat" Easy (%)[b]		
Year 1	**Glades (*n* = 51)**	**Non-Glades (*n* = 338)**	
Advice on caring for children or handling household problems	84	71	
Help with housework or caring for children**	78	55	
Talk about problems or personal or private things**	74	53	
Year 2	**Glades (*n* = 49)**	**Non-Glades (*n* = 315)**	**Outside TGA (*n* = 25)**
Advice on caring for children or handling household problems*	80	64	79
Help with housework or caring for children**	76	51	64
Talk about problems or personal or private things*	74	54	63
Year 3	**Glades (*n* = 48)**	**Non-Glades (*n* = 302)**	**Outside TGA (*n* = 40)**
Advice on caring for children or handling household problems	81	73	63
Help with housework or caring for children*	81	60	64
Talk about problems or personal or private things	65	60	53

[a] Data were weighted to account for the oversampling of mothers in the Glades and mothers assessed "at risk."
[b] Based on a 5-point scale: "very easy," "somewhat easy," "between hard and easy," "somewhat hard," and "very hard."
Chi-square tests indicated that differences among the sample groups are statistically significant at *$p < .05$, **$p < .01$.

Summary

Mothers in the third year continued to voice high satisfaction with the level of informal support they receive. Consistent with previous years, if mothers have husbands or partners, they most often received support from them, although the mean level of support from husbands and partners was lower in year 3 compared with year 2. Otherwise, mothers relied primarily on their family, especially siblings and mothers or stepmothers. In addition to family members, mothers depended on friends for support, although less than half of the sample reported receiving support from a friend. The mean support score based on mothers' reports of help received from family and friends in the third year was similar to that in the second year; on average, both scores were lower than the mean support score for the first year. In addition, except in the area of child discipline, we also saw a decline in the frequency with which different kinds of support were provided by husbands or partners, other family members, and friends.

In contrast to the first 2 years, more than half of the mothers reported receiving support from one or more individuals in the community, either advice on children or household problems or help with money, food, or clothing. There was an increase from year 2 (15%) to year 3 (29%) in the percentage of mothers who cited doctors as a form of community support. There was also an increase in the percentage of mothers reporting support from their child's teacher. As in the previous year, almost one-fifth (18%) of mothers said they received support from a place of worship.

Mothers' perceptions of their access to social support, regardless of source, fluctuated over time. There was a drop from year 1 to year 2 in the percentage of mothers who said it was "very easy" to get advice on caring for children or taking care of household problems or get help with housework or childcare. However, by the third year, more than half of the respondents reported that it was "very easy" to get this kind of support. In addition, there were declines from the first 2 years to the third year in the percentage of mothers who reported that it was "very hard" getting help with housework or childcare (15% vs. 9%) and the percentage who reported that it was "very hard" to talk to someone about things that are very personal or private (22% vs. 15%).

These trends in the survey data were supported by the qualitative data, which suggested a variety of reasons for these changes over time. Sometimes relatives are no longer able to help with childcare or turn out to be unreliable caregivers, so mothers have to find other sources of help. Over time, if they can afford it, mothers living with relatives or friends increasingly try to set up households of their own—although they may continue to share resources, such as childcare and food stamps. As their children grow, some mothers convey an increasing desire to be independent. They also express more confidence in their parenting abilities, and, although respondents' mothers remain an important source of information and support, respondents appear to be turning more to doctors, teachers, and other nonfamily for information and support than when their children were younger.

USE OF HEALTHY BEGINNINGS AND OTHER FORMAL SERVICES

A central question of the longitudinal study is what formal services are available and used by families of young children in the TGAs. Data on service use comes from both administrative data records and mothers' self-reports. This chapter first summarizes information from the FOCiS database about the use of maternal and child health services in the Healthy Beginnings system by mothers in the TGA birth cohort and mothers in the year 3 study sample.[48] We then present findings from the third-year interview, in which mothers were asked to identify a range of service areas in which they received help during the previous year.

Use of Healthy Beginnings

Healthy Beginnings is a growing network of integrated and coordinated prevention and early intervention health and social services for pregnant women who are at risk of poor birth outcomes and for children from birth to age 5 who are not on target for developmental or health outcomes and who, without the support of the program, may have an increased risk of abuse or neglect or a diminished chance of being ready for school.[49] Focused on improving birth outcomes, reducing child maltreatment, and promoting early childhood development and readiness to learn, the Healthy Beginnings system includes universal risk screening, targeted home visitation programs, and referrals and linkages to a range of services within and outside the system. Services also include assistance connecting with a payer source and/or medical home, health education/health literacy, identification of and treatment for perinatal depression, nutrition counseling, childbirth and breastfeeding education, and family support services ranging from telephone counseling to intensive home visiting services. Qualified providers also deliver developmentally appropriate early childhood therapeutic and family supportive services to eligible families and children birth to age 5 through home visits, consultations at childcare, or in a variety of client-convenient locations. These services include parenting support/education, infant mental health/social-emotional wellness including parent/child bonding, family therapy, and early literacy.

Early identification is a key preventive service for all pregnant and postnatal women and children birth to age 5. According to a recent description of Healthy Beginnings, the system will consist of two entry agencies, based on assessment information.[50] Common entry points to the system during the period of this study are the Healthy Mothers/Healthy Babies Coalition of Palm Beach County; Healthy Start/Healthy Families; and the Women's Health Initiative (WHIN).

---

[48] The FOCiS database replaced the Right Track database as the source of information on mothers served by the Healthy Beginnings system in November 2007.

[49] Healthy Beginnings, which formally began operations in 2006, was preceded by other maternal child health networks and systems. The first, the Healthy Start Coalition, began in 1992. It evolved into Maternal Child Family Health Alliance, which was reconstituted as the Maternal and Child Health Partnership (MCHP) in 2004. Agencies providing services in the system have also changed over time. Whereas some agencies have simply changed their names, others have ceased operation or left the system; for example, the American Lung Association left the system in May 2005, the Haitian American Community Council in September 2006, and BANK in 2007 (personal communication with Carol Scott and Regina Battle, CSC, September 2008). Analysis of FOCiS data for these agencies after these dates were not included in counts of services in the Healthy Beginnings system.

[50] Personal communication with Carol Scott and Regina Battle, CSC, September 2008.

Mothers enter the system prenatally or postnatally based on the Healthy Start Prenatal and Infant Risk Screen or a home assessment, but a majority of mothers have entered the system through the Healthy Mothers/Healthy Babies Coalition, whose staff of hospital liaisons administer the 10-item Healthy Start Risk Screen to as many newly delivered mothers as possible. On a scale from 0 to 10, a score of 4 or higher is considered an indicator of possible risk. Mothers who score 4 or higher are encouraged to accept a home visit from a Healthy Start nurse. Mothers who receive lower scores are not offered a home visit but may request one.[51] Subsequently, in a home visit, mothers are reassessed and identified as having services needs of E, 1, 2, or 3. Mothers who are assigned levels 2 and 3 are thought to need more frequent or more varied services and thus are loosely referred to as "high risk," whereas mothers with service levels of E or 1 are designated as "not high risk." Mothers who are screened or assessed at a level 3 are automatically assigned to intensive care coordination services.[52]

Table 49 describes the number of mothers who received services in the Healthy Beginnings network and those who did not receive these services, based on records from the FOCiS database. Table 49 presents characteristics of the cohort of mothers who gave birth in Palm Beach County in 2004 and 2005, from which the study interview sample was drawn. For comparison purposes, we also analyzed administrative data on the cohort of mothers who gave birth during the subsequent year, 2006. In 2004 and 2005, there were 29,622 birth events

Table 49. Percentage of Palm Beach County Mothers in Healthy Beginnings FOCiS Data System 2004-2006[a]

Sample	Birth Events[b]	In HB FOCiS Data System		In HB FOCiS Activity File		HB Treatment Activity	
	N	*n*	%	*n*	%	*n*	%
2004-2005 Birth Cohort	29,622	23,575	80	20,035	68	8,036	27
Non-TGAs	17,184	12,730	74	10,089	59	2,935	17
TGAs	12,438	10,845	87	9,946	80	5,101	41
2006 Birth Cohort	15,433	12,541	81	9,101	59	4,222	27
Non-TGAs	8,717	6,602	76	3,700	42	1,559	18
TGAs	6,716	5,939	88	5,401	80	2,663	40
2004-2006	45,055	35,116	80	29,136	65	12,258	27
Non-TGAs	25,901	18,332	75	13,789	53	4,494	17
TGAs	19,154	16,784	88	15,347	80	7,764	41
Year 3 Study Sample	390	388	99	388	99	313	80

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

[b] The birth of twins, triplets, and other multiples are counted as one birth event. Of the mothers who gave birth in Palm Beach County in 2004-2006, 9 percent had more than a single birth event; 11 percent of TGA mothers had more than a single birth event.

[51] At the time we began recruiting, the Healthy Start program included a universal home visiting component for all newly delivered mothers. In spring 2005, the program changed to target mothers who are, based on a risk screen score, identified as most in need of and more likely to use services. Mothers in a "special low risk" group are also offered a home visit if they are younger than 19, new to the county, have delivered their first child with no or only late-term prenatal care, have no identified pediatrician, have difficulty bonding with their baby, or seem to lack social support (Palmer, 2005; Walsh, 2005).

[52] Risk screen and assessment scores also are likely to change over time with subsequent contacts with health care and other service providers.

(counting multiples as one) recorded in the Vital Statistics data for Palm Beach County where the mother's county of residence is listed as Palm Beach. Of those, 23,575 (80%) mothers who gave birth had contact with the Healthy Beginnings system, and 8,036 (27%) received treatment in the Healthy Beginnings System.

Mothers who gave birth in the TGAs were more likely to have contact with the Healthy Beginnings system and receive services from the system in the years 2004-2005 (41%) and in 2006 (40%) than mothers outside the TGAs (17%-18%). Moreover, the mothers in our study sample were about twice as likely as other mothers in the TGAs to have received Healthy Beginnings treatment services; 80 percent of these mothers had records of treatment activity in the FOCiS database (see Table 50).[53]

Table 50 also describes the number and characteristics of mothers who received services in the Healthy Beginnings network and those who did not receive these services, which are recorded in the FOCiS database. Among mothers in the TGA 2004-2005 birth cohort, almost half (41%) received care coordination and, in some cases, additional services. The 2006 TGA birth cohort was similar with 40 percent who received care coordination and other services. As expected, given the maternal characteristics targeted by the Healthy Beginnings system, results show that mothers who received services were more likely to be teen mothers, be unmarried, have less than a high school education, be Hispanic, and be foreign-born. The year 3 study sample had higher proportions of unmarried mothers, teen mothers, those with less than a high school education, Hispanic mothers, foreign-born mothers, and mothers who gave birth to a low-birth-weight baby in the Healthy Beginnings treatment group than the larger TGA population.

Table 50. Characteristics of Mothers in the TGA Birth Cohort by Healthy Beginnings/FOCiS Service Category [a]

Maternal Characteristic	TGA 2004-2005 Birth Events (n = 12,438)	TGA 2004-2005 HB Treatment (n = 5,101)	TGA 2006 Birth Events (n = 6,716)	TGA 2006 HB Treatment (n = 2,663)	Year 3 Study Sample Birth Events (n = 390)	Year 3 Study Sample HB Treatment (n = 313)
	%	%	%	%	%	%
Unmarried Mother[b]	58	72	60	73	73	74
Teen Mother[b]	14	21	14	21	18	21
< HS Education[b]	39	58	40	60	55	62
Black	36	38	34	32	38	34
Hispanic	39	51	43	59	55	62
Foreign-Born	47	60	48	63	57	65
Low Birth Weight[c]	9	11	9	11	11	11

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

[b] If a mother was recorded "unknown" for marital status, she was counted as unmarried; if "unknown" for age, she was counted as a teen mother; if "unknown" for education, she was counted as having less than a high school education.

[c] In the case of twins, only one birth weight was used to compute whether the child was underweight (less than 2,500 grams).

[53] Again, as noted in Chapter 2, although we weighted the data to adjust for the over-sampling of mothers from the Glades and "at risk" mothers, recruiters could not contact all mothers who gave birth in 2004-2005 equally, and not all groups of mothers agreed to participate at the same rates. Thus, the study sample still has higher proportions of some risk characteristics than the population of mothers in the TGAs and mothers in the study sample were more likely to have received services in the Healthy Beginnings system.

Figure 3. Characteristics of Mothers in TGA Birth Cohorts by Healthy Beginnings Service Category

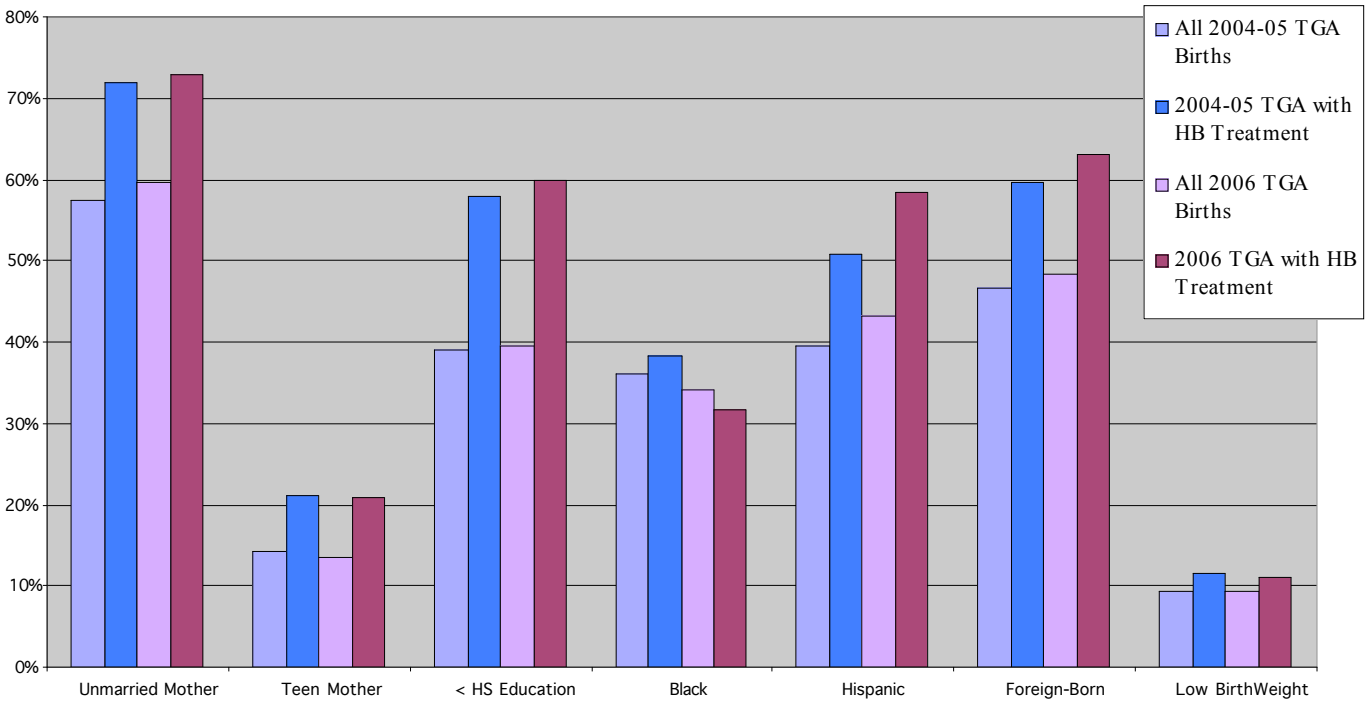


Figure 4. Characteristics of Mothers in Year 3 Sample by Healthy Beginnings Service Category

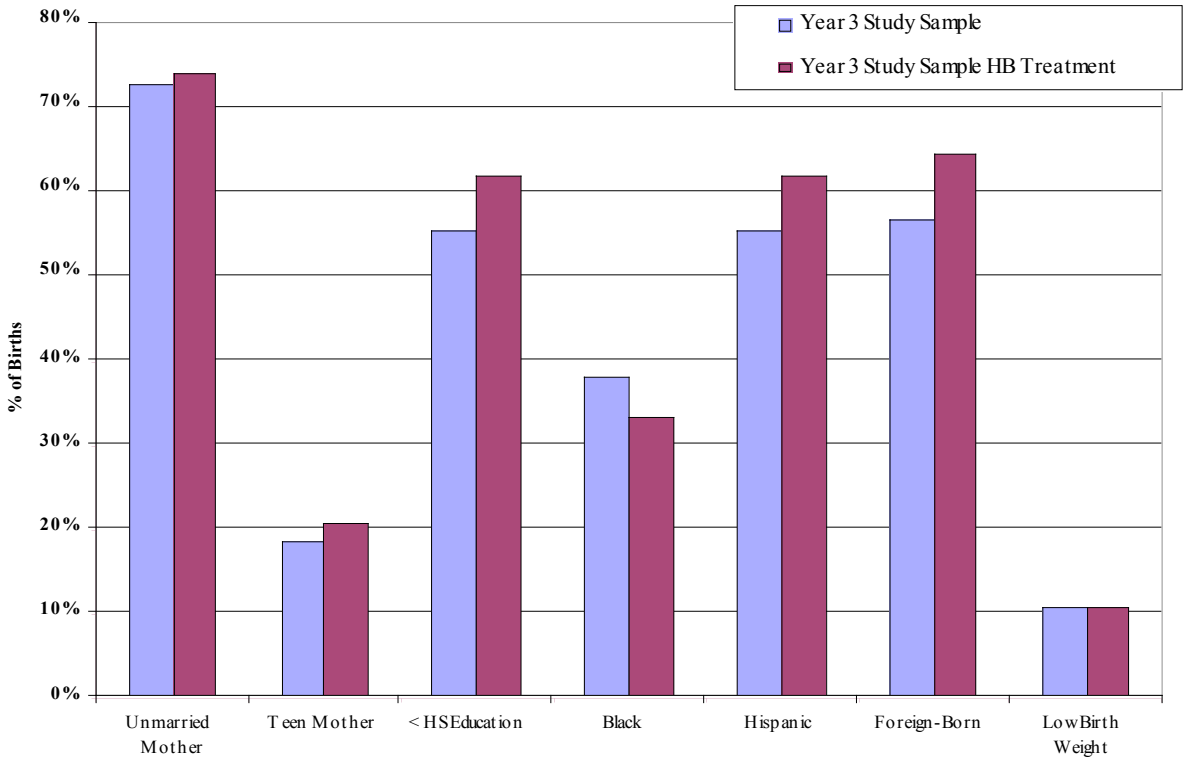


Table 51 shows the number of mothers who had a prenatal or postnatal risk screen score recorded in FOCiS for 2004-2005 as well as in 2006. Overall, 72 percent of mothers in Palm Beach County with newborns in 2004-2006 had a risk screen score recorded in FOCiS, and 17 percent of them scored "at risk." A higher percentage of mothers in the TGAs (80%) had a risk screen score in FOCiS than mothers outside the TGAs (67%). A higher percentage of screened mothers in the TGAs (33%) were considered "at risk" than those outside the TGAs (16%). Not surprisingly, given the items on the Healthy Start risk screen, during 2004-2006, children born to mothers who are unmarried, teenagers, have less than a high school education, are Black or Hispanic or have a low birth-weight baby were more likely to have an "at risk screen."

Table 51. Risk Screen Scores of Mothers with Newborns, 2004-2006 [a]

Sample	*N*	Risk Screen Score in HB FOCiS Database		"At Risk" Screen Score[b]		
		n	% Mothers	*n*	% All Mothers	% Mothers Screened
2004-2005 Birth Cohort	29,622	20,919	71	4,933	17	24
Non-TGAs	17,184	11,156	65	1,765	10	16
TGAs	12,438	9,763	78	3,168	25	32
2006 Birth Cohort	15,433	11,632	75	2,904	19	25
Non-TGAs	8,717	6,088	70	1,015	12	17
TGAs	6,716	5,545	83	1,889	28	34
2004-2006	45,055	32,551	72	7,837	17	24
Non-TGAs	25,901	17,244	67	2,780	11	16
TGAs	19,154	15,308	80	5,057	26	33
Year 3 Study Sample	390	365	93	168	43	46

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

[b] "At Risk" indicates a score of four or above on the Healthy Start risk screen

Table 52. Characteristics of TGA Mothers with Healthy Beginnings Risk Screens, 2004-2006 [a]

	TGA 2004-2005		TGA 2006		Year 3 Study Sample	
	Birth Events (*n* = 12,438)	HB "at Risk" (*n* = 3,168)	Birth Events (*n* = 6,716)	HB "at Risk" (*n* = 1,889)	Birth Events (*n* = 390)	HB "at Risk" (*n* = 168)
	%	%	%	%	%	%
Unmarried Mother	58	85	60	85	75	90
Teen Mother	14	21	14	21	21	20
< HS Education	39	70	40	70	57	77
Black	36	45	34	45	43	35
Hispanic	39	46	43	46	51	61
Foreign-Born	47	53	48	53	53	61
Low Birth Weight	9	17	9	17	12	16

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

To supplement information provided by the Healthy Start screen, we created a risk index based on Vital Statistics data indicating the presence of the following characteristics in a mother: no prenatal care, less than high school education, unmarried, foreign-born, used WIC during pregnancy, smoked during pregnancy, complications during pregnancy (not including caesarean section delivery), complications during delivery, the mother was a teenager, the baby was underweight, or the baby was premature. Calculating Chapin Hall's risk index for those who were assessed by the Healthy Beginnings system shows that mothers who were assessed "at risk" had a higher mean Chapin Hall risk index as well as a higher mean postnatal risk score in the Healthy Beginnings database.

Table 53. Healthy Beginnings and Chapin Hall Mean Risk Index for TGA Birth Cohorts and Year 3 Study Sample [a]

	Risk Screen Score in HB FOCiS		**Chapin Hall "At Risk" Screen Score**	
	Mean Risk Index	□	Mean Risk Index	□
2004-2005 Birth Cohort	2.74	*1.78*	4.06	*1.52*
Non-TGAs	2.24	*1.72*	3.97	*1.58*
TGAs	3.31	*1.67*	4.10	*1.48*
2006 Birth Cohort	2.61	*1.83*	4.00	*1.59*
Non-TGAs	2.11	*1.76*	3.87	*1.65*
TGAs	3.16	*1.74*	4.06	*1.55*
Year 3 Study Sample (*n* = 390)	3.63	*1.50*	4.09	*1.26*

[a] Source: Vital Statistics and FOCiS (2003-2006). Data for the year 3 study sample were weighted to account for over-sampling of mothers "at risk" and mothers residing in the Glades TGA.

Table 54 presents additional information about the number of mothers who received different types of services for the 2004-2005 birth cohort as well as the 2006 birth cohort. By design, mothers who received intensive care coordination services were those who were assessed as being "at risk" and designated eligible for Level 2 or Level 3 services on the Healthy Start assessment. Thus, these mothers were more likely than mothers who only received care coordination services to be unmarried, be a teen, have less than a high school education, be Black or Hispanic, and have given birth to a low-birth-weight baby. Half (52%) of the 2,360 mothers in the 2004-05 birth cohort who received intensive care coordination also received Family Support Planning, a service provided to mothers who were designated Level 3 in their in-home risk assessment. In 2006, 50 percent of the mothers who received intensive care coordination received Family Support planning.

Unmarried mothers and teen mothers follow the same trend: they are a higher percentage of the intensive care coordination population than of the care coordination only population and even more over-represented in the population of mothers who received family support planning. On the other hand, the opposite trend is true for foreign-born mothers: intensive care coordination mothers included a lower percentage of foreign-born mothers than of their care coordination only counterparts, and family support planning mothers included an even lower percentage of foreign-born mothers.

Table 54. Characteristics of TGA Birth Cohorts by Type of Services in Healthy Beginnings System [a]

	TGA 2004-2005 (*N* = 5,101)			TGA 2006 (*N* = 2,663)		
	Care Coordination Only[b]	Intensive Care Coordination[c]	Family Support Planning[d]	Care Coordination Only	Intensive Care Coordination	Family Support Planning
	(*n* = 2,741)	(*n* = 2,360)	(*n* = 1,247)	(*n* = 1,450)	(*n* = 1,213)	(*n* = 612)
Sample Group	%	%	%	%	%	%
TGA birth events	22	19	10	22	18	9
With HB activity	54	46	24	54	46	23
Maternal Characteristic						
Unmarried mother	65	78	79	68	79	81
Teen mother	17	26	27	17	25	29
< HS Education	49	68	63	53	68	69
Black	37	39	46	31	33	37
Hispanic	49	53	45	59	58	54
Foreign-born	61	58	49	65	61	56
Low birth weight	11	12	14	11	11	13

[a] Source: Vital Statistics and FOCiS (2003-2007). Names of agencies providing care coordination and intensive care coordination varied over this period of time: for example, American Lung Association left the system in May 2005, the Haitian American Community Council in September 2006, and BANK in 2007. Services recorded in FOCiS for these agencies after these dates were not included in counts of services in the Healthy Beginnings system.

[b] Includes mothers who consented to services and received care coordination only and not intensive services. Care coordination includes the following activity codes: 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 3320, 3321, 4501, 6515, 6516, 8002, 8004, 8006, 8008, 8013, and 8026. Care coordination services do not include the codes of 3102 (participant needs assessment) or 3215 (initial assessment). Care coordination activities were provided by the following agencies: BANK, Healthy Mothers/Healthy Babies Coalition, Healthy Start/Healthy Family Nurses, Oakwood, Parent-Child Center, Center for Family Services, Planned Parenthood, HUGS, and Comprehensive AIDS Program.

[c] Includes mothers who received intensive care coordination under the same activity codes listed above, but these services are provided by the following agencies: Healthy Mothers/Healthy Babies Coalition, Nurture the Future, NOAH, Families First, Guatemalan Mayan Center, Sickle Cell Foundation, Haitian American Council Esereh Youth and Family Center, American Lung Association, WHIN, and Minority Development and Empowerment, Inc.

[d] Family support planning (FSP) is provided to a subgroup of mothers receiving intensive care coordination and includes activity codes 3321 and 3322, which can be provided by any agency.

Table 55 presents additional information about the survey sample mothers who received different types of services. As noted above, mothers who received intensive care coordination services were those who were assessed as being "at risk" (so-called Level 2 or Level 3) on the Healthy Start assessment. The demographics of the mothers in different treatment groups was different for the mothers in our survey sample than in the larger 2004-05 TGA cohort. Higher percentages of the survey sample mothers received care coordination only rather than intensive care coordination with the exception of Black and foreign-born survey sample mothers and mothers of low-birth-weight babies. Over three-quarters (84%) of the initial year 3 survey sample who received intensive services were designated Level 3 on the Healthy Start assessment and also received family support planning.

Table 55. Characteristics of Year 3 Study Sample by Type of Services in Healthy Beginnings System [a]

	Care Coordination Only (n = 146)	Intensive Care Coordination (n = 167)	Family Support Planning (n = 99)
Sample Group	%	%	%
Year 3 study mothers	37	43	26
Mothers with HB activity	46	53	31
Maternal Characteristic			
Unmarried mother	71	76	75
Teen mother	17	24	29
< HS education	60	64	57
Black	29	37	41
Hispanic	68	56	51
Foreign-born	70	60	47
Low birth weight	7	13	15

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

Table 56 presents the mean number of service contact days for mothers who received Healthy Beginnings treatment before and after birth. Mothers in the 2004-2005 TGA birth cohort who received care coordination services received a mean of about 2 days of prenatal and postnatal services. Mothers who received intensive care coordination services received a mean of almost 8 days of prenatal services and more than 22 days of postnatal services. Mothers with family support plans received less than 1 day of these services prenatally and almost 2 days postnatally. The 2006 birth cohort showed similar patterns.

For all categories of service, more mothers received care from the Healthy Beginnings system postnatally than prenatally. Also, mothers who did get care prenatally had fewer days of care on average than mothers who received care postnatally. Intensive care coordination services were most likely to be given prenatally or postnatally. Enhanced services were the least likely to be used prenatally; outside referrals were the least likely to be used postnatally.

As shown in Table 57, similar to the TGA birth cohorts, the survey sample received more days of care postnatally than prenatally. However, postnatally, mothers in the year 3 study sample received higher percentages of services than mothers in the TGA birth cohorts. Since our mothers were more likely than the overall 2004-2005 TGA population to get services, this is not surprising. The year 3 study mothers who received care coordination services received a mean of 1.7 days of prenatal services and 3.2 days of postnatal services. Mothers who received intensive services received a mean of 9.1 days of prenatal services and 30 days of postnatal services. Mothers with family support plans received a mean of 0.7 days prenatal FSP services and 4.3 days postnatally.

Table 56. Healthy Beginnings Prenatal and Postnatal Services and Referrals for Mothers in 2004-2005 and 2006 TGA Birth Cohorts [a]

Level of Service	TGA 2004-2005							
	Total Mothers		Prenatal Care[b]			Postnatal Care		
	N	Mean Days of Care	*n*	%	Mean Days of Care	*n*	%	Mean Days of Care
Care Coordination Only	2,741	4.0	1,530	56	1.9	2,291	84	2.1
Intensive Care Coordination	2,360	30.2	1,775	75	7.9	2,176	92	22.3
Family Support Planning	1,247	2.4	611	49	0.6	1,042	84	1.8
Enhanced Services[c]	1,983	5.1	617	31	0.7	1,780	90	4.4
Outside Referrals	1,309	7.0	600	46	1.3	1,049	80	3.8

Level of Service	TGA 2006							
	Total Mothers		Prenatal Care[b]			Postnatal Care		
	N	Mean Days of Care	*n*	%	Mean Days of Care	*n*	%	Mean Days of Care
Care Coordination Only	1,450	3.9	832	57	2.2	1,189	82	1.7
Intensive Care Coordination	1,213	23.8	964	80	7.4	1,095	18	16.5
Family Support Planning	612	2.1	324	53	0.7	510	83	1.4
Enhanced Services	1,522	4.8	661	43	1.3	1,352	89	3.4
Outside Referrals	806	5.4	379	47	1.1	614	76	2.6

[a] Source: Vital Statistics and FOCiS (2003-2007).

[b] Prenatal activity includes any activity attributed to the child's mother occurring 300 days or less before the child's birth.

[c] Enhanced services were defined through conversations with CSC and are defined by activity codes 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 40, 41, 42, 43, 44, 47, 48, 49, 50, 51, 4501, 6515 , 6516, 8002, 8004, 8006, 8008, 8013, 8026, provided by any agency.

Table 57. Healthy Beginnings Prenatal and Postnatal Services and Referrals for Year 3 Study Sample [a]

Level of Service	Year 3 Study Mothers							
	Total Mothers		Prenatal Care[b]			Postnatal Care		
	N	Mean Days of Care	*n*	%	Mean Days of Care	*n*	%	Mean Days of Care
Care Coordination Only	147	4.9	76	52	1.7	143	98	3.2
Intensive Care Coordination	167	39.0	137	82	9.1	165	99	29.9
Family Support Planning	99	3.2	54	54	0.8	159	98	2.4
Enhanced Services	162	5.1	44	27	0.7	159	98	4.5
Outside Referrals	106	5.7	51	48	1.4	93	88	4.3

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

[b] Prenatal activity includes any activity attributed to the child's mother occurring 300 days or less before the child's birth.

Another way of dividing the services that the Healthy Beginnings system provides is by "enhanced" and "not enhanced." Enhanced services are a subset of the treatment services, and they can be provided by any agency. They are considered to be the more rigorous services, and exclude screening and general case management. As shown in Table 58, the most common category of enhanced services was translation services, followed by breastfeeding services. For all categories with the exception of interconceptional education and childbirth education, more mothers used these services postnatally than prenatally.

Table 58. Use of Enhanced Services by Mothers in TGA Birth Cohorts [a]

Type of Enhanced Service	*N* Mothers	% Mothers receiving HB treatment	*n* Mothers with postnatal activity	*n* Mothers with prenatal activity
2004-2005 TGA Birth Cohort				
Translation	1,475	29	467	1,333
Breastfeeding	644	13	133	588
Parenting Support and Education	303	6	65	259
Psychosocial Counseling	209	4	52	185
Nutrition	158	3	72	96
Childbirth Education	110	2	76	42
Interconceptional Education/Counseling	61	1	5	57
Smoking Cessation[b]	22	0	11	13
2006 TGA Birth Cohort				
Translation	1,277	48	539	1,152
Breastfeeding	446	17	124	391
Psychosocial Counseling	129	5	70	94
Parenting Support and Education	121	5	54	96
Nutrition	54	2	34	38
Interconceptional Education/Counseling	53	2	14	43
Childbirth Education	38	1	20	24
Smoking Cessation	5	0	5	0

[a] Source: Vital Statistics and FOCiS (2003-2007).
[b] The American Lung Association left the Healthy Beginnings system in May 2005, which might have reduced the availability of smoking cessation services.

Table 59 shows a similar pattern emerging in the study sample: with the exception of services that directly target prenatal women, mothers used enhanced services more often in the postnatal period than prenatally. In addition to directly providing services to mothers through its partners, the Healthy Beginnings system also refers mothers to outside assistance. Table 60 shows these outside referrals. All 3 cohorts look similar, and all 3 cohorts are more likely to be referred to outside services in the postnatal period than the prenatal period.

Table 59. Use of Enhanced Services by Mothers in the Year 3 Study Sample (*N*=390)[a]

Type of Enhanced Service	Number of Mothers	% Mothers receiving HB Treatment	Number of Mothers	
			Prenatal Services	Postnatal Services
Translation	81	26	103	28
Breastfeeding	17	5	80	16
Parenting Support and Education	27	9	24	7
Psychosocial Counseling	19	0	16	6
Nutrition	8	2	6	3
Childbirth Education	17	5	9	12
Interconceptional Education/Counseling	6	2	6	0
Smoking Cessation	1	0	0	1

[a] Source: Vital Statistics and FOCiS (2003-2007). Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

Table 60. Outside Service Referrals for 2004-2005 and 2006 TGA Cohorts and Year 3 Study Sample[a]

Referral Type	2004-2005 TGA (*N*=12,438)			2006 TGA (*N*=6,716)			Year 3 Study Sample (*n*=390)[b]		
	All Mothers *N*	Pre-natal *n*	Post-natal *n*	All Mothers *N*	Pre-natal *n*	Post-natal *n*	All Mothers *N*	Pre-natal *n*	Post-natal *n*
Access to care: Insurance	152	68	89	91	51	48	12	6	6
Childcare	125	14	115	74	9	67	12	1	11
Counseling (Child or Adult)	184	71	132	79	48	36	16	5	11
Domestic Violence	23	5	19	12	2	10	1		1
Educational Services	141	48	100	63	21	45	12	1	11
Employment Services	60	16	46	28	5	23	2		2
Financial Services	178	67	124	67	25	49	23	8	17
Housing	126	48	85	47	22	28	11	4	8
Immigration Services	24	7	18	9	5	4	2		2
Medical Referrals (Child or Adult)	253	79	194	123	45	88	27	5	22
Nutrition and Baby Supplies	642	277	476	325	135	237	56	31	38
Other	650	222	533	355	112	294	60	16	52
Parenting or Health Education	312	97	243	185	63	140	31	10	24
Teenage-Targeted Programs	20	8	12	17	4	14	1	1	0
Transportation	475	184	370	344	140	258	38	15	32

[a] Source: Vital Statistics and FOCiS (2003-2007).
[b] The study sample was drawn from the 2004-2005 TGA cohort. Data for the year 3 study sample were weighted to account for oversampling of mothers "at risk" and mothers residing in the Glades TGA.

Use of Healthy Beginnings by Age of Child: Year 3 Sample

As described above, a large majority (80%) of the year 3 study sample received care coordination services from the Healthy Beginnings system around the birth of the focal child. Given that mothers were recruited through two core programs in the system—the Healthy Mothers/Healthy Babies Coalition and Healthy Start/Healthy Families—this is not surprising. As shown in Figure 5 and Table 60, mothers received a majority of services—either care coordination or intensive care coordination—during the 3 months before and the 6 months after they gave birth. Half (50%) of the year 3 sample received services in the third trimester; almost three-fourths (72%) received services during the first 3 months after their child's birth; and more than half (57%) received services between the subsequent 3 months. Very few mothers who received care coordination services only continued to receive these services after 6 months. Of the mothers receiving intensive care coordination, however, a little more than a quarter (29%) received services between 6 and 9 months after giving birth, and 17 percent received services at the end of the first year.

Figure 5. Mean Days of Healthy Beginnings Service for Year 3 Sample by Age of Child

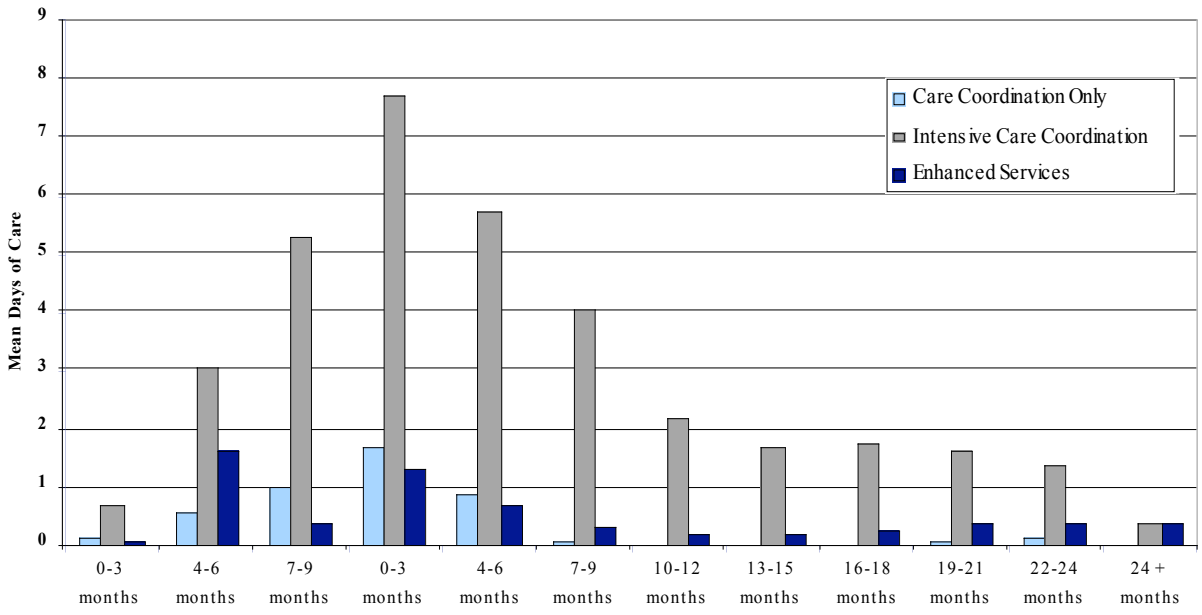


Table 61. Days of Care Coordination by Age of Target Child, 2004-2006, for Year 3 Sample[a]

Service Type[b]	Totals			Prenatal[b]			Postnatal[b]								
	Total	Total prenatal	Total postnatal	0-3 months	4-6 months	7-9 months	0-3 months	4-6 months	7-9 months	10-12 months	13-15 months	16-18 months	19-21 months	22-24 months	24 + months
Care Coordination Only[c]															
% (*N* = 390)	38	20	37	2	11	17	32	20	1	1	0	0	2	2	4
Mean days service[d]	4.9	1.7	3.2	0.1	0.6	1.0	1.7	0.9	0.1	0.0	0.0	0.0	0.1	0.1	0.0
Maximum days	18	11	14	4	6	4	8	5	4	2	0	1	2	4	7
Intensive Care Coordination[e]															
% (*N* = 390)	43	36	42	8	22	32	40	38	29	17	13	12	11	9	4
Mean days service	39.0	9.1	29.9	0.7	3.0	5.3	7.7	5.7	4.0	2.2	1.7	1.8	1.6	1.4	0.4
Maximum days	187	36	160	14	21	21	28	30	21	25	18	25	20	28	7
Enhanced Services															
% (*N* = 390)	42	12	41	2	4	9	30	15	6	4	3	5	7	5	4
Mean days of service	5.1	0.7	4.5	0.1	1.7	0.4	1.3	0.7	0.3	0.2	0.2	0.3	0.4	0.4	0.4
Maximum days	51	12	51	5	5	7	8	11	9	7	8	10	11	23	7

[a] Source: FOCiS (2003-2007). Names of agencies providing care coordination and intensive care coordination varied over this period of time: for example, American Lung Association left the system in May 2005, the Haitian American Community Council in September 2006, and BANK in 2007. Services recorded in FOCiS for these agencies after these dates were not included in counts of Healthy Beginnings services. Statistics are weighted to adjust for the oversampling of Glades mothers and mothers "at risk."

[b] Services are designated prenatal or postnatal with reference to date of birth of focal child. Some postnatal services may have been received in conjunction with the birth of a subsequent child.

[c] Includes mothers who consented to services and received care coordination only and not intensive services. Care coordination includes the following activity codes: 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 3320, 3321, 4501, 6515, 6516, 8002, 8004, 8006, 8008, 8013, and 8026. Care coordination services do not include the codes of 3102 (participant needs assessment) or 3215 (initial assessment). Care coordination activities were provided by the following agencies: BANK, Healthy Mothers/Healthy Babies Coalition, Healthy Start/Healthy Family Nurses, Oakwood Parent-Child Center, Center for Family Services, Planned Parenthood, HUGS, and Comprehensive AIDS Program.

[d] Mothers may receive more than one type of service on a given date; "days of service" refers to the number of different days that one or more services were provided.

[e] Includes mothers who received intensive care coordination under the same activity codes listed above, but these services are provided by the following agencies: Healthy Mothers/Healthy Babies Coalition, Nurture the Future, NOAH, Families First, Guatemalan Mayan Center, Sickle Cell Foundation, Haitian American Council Esereh Youth and Family Center, American Lung Association, WHIN, and Minority Development and Empowerment, Inc.

Use of Other Formal Services

Administrative records on participation in Healthy Beginnings services are just one source of information on mothers' service use. In the annual in-person surveys, we also asked mothers about other services they received and their needs for services in a wide range of areas. These included meeting basic needs of families, such as food, clothing, and housing; childcare; medical and mental health care; and addressing concerns about children's health and development. We defined service use broadly as "help received from any agency, program, or professional" to meet these needs. For example, mothers coded as receiving help with food included mothers who received assistance through any of these sources, including the WIC or Food Stamp Program or a church food pantry. If mothers received help, they were asked how satisfied they were with their contact with the provider. If mothers did not report receiving help in a particular service area, they were asked whether or not they had had concerns in that area and sought help for those concerns. (See Section C in the third-year in-person maternal interview in Appendix B for an example of how these questions were framed.)

In year 3, all but seventeen mothers, or 96 percent of the sample, reported receiving help from a program, agency, or professional in the past year for at least one area of concern for basic family needs. The average number of service areas in which mothers received help for basic family needs was two, which is less than the average number of reported services in years 1 and 2. In year 3, eleven percent of mothers received help for five or more service areas, which is lower than in the first two years, in which 13 percent reporting using five or more services in each year.

Services for Basic Family Needs

In general, across all 3 years, mothers were more likely to have concerns about and receive help in areas defined as basic family needs than to have specific concerns related to their children's health and development. Consistent with the first and second years of the study, mothers in the third year reported receiving help most often with health care (92%) and food (70%) the previous year (see Table 44). The percentage of mothers who reported help with food was less in the third year than in the second year (86%), which is consistent with the decline in use of WIC and food stamps shown in Table 6. Less than a third of the sample received help with any other area of service use, with family planning, dental care, and childcare the next most frequent areas in which mothers reported receiving assistance.

With respect to other service needs, Table 62 also shows that only 12 percent of the year 3 sample reported receiving assistance with parenting information, compared with the 24 percent reported in the previous year. In addition, less than 10 percent of the mothers recalled receiving help with paying rent or bills, clothing for children, housing or shelter, finding employment, emergency shelter, legal issues, mental health or substance abuse issues, and transportation. Just 7 percent of mothers with limited English proficiency reported receiving help translating things into English.

Table 62. Help Received for Basic Family Needs[a]

Service Area	% Year 1 (*N* = 390)	% Year 2 (*N* = 390)	% Year 3 (*N* = 390)
Health care for mother or children	73	95	92
Getting enough food	67	86	70
Family planning or birth control	--[b]	36	30
Dental care	19	25	26
Childcare	14	20	23
Parenting information	70	24	12
Paying rent or bills	9	9	8
Housing	--[b]	5	7
Translating things into English	--[b]	10[c]	7[c]
Transportation	17	14	6
Legal issues	2	2	5
Employment	4	6	4
Clothes for children	6	5	3
Mental health or substance abuse	2	2	3
Emergency shelter	--[b]	3	1

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Item not included in year 1 survey. (Housing and emergency shelter were combined as one item in year 1.)
[c] Only those respondents who do not speak English as their primary language were asked this question (n = 199)
Paired sample t-tests indicated the following differences were statistically significant at $p < .05$: health care year 1 vs. 2; food year 1 vs. 2 and food year 2 vs. 3; family planning year 2 vs. year 3; dental care year 1 vs. 2; childcare year 1 vs. 2; parenting information year 1 vs. 2, and year 2 vs. 3; transportation year 2 vs. year 3; housing year 1 vs. 2; and legal year 2 vs. 3.

As in previous years, satisfaction levels with all areas of service were high, with more than three-fourths of the those mothers using services describing themselves as "very satisfied" on a 4-point scale with those services. As shown in Table 63, there was a sizeable increase in the percentage of mothers who reported being "very satisfied" with mental health and substance abuse services between year 1 (49%) and year 2 (85%) as well as in the percentage of mothers who reported being "very satisfied" with assistance paying rent or bills between year 2 (83%) and year 3 (98%).

Child Development Services

Fewer mothers received services pertaining to the health and development of their children (e.g., their physical and mental health, social relationships, and school progress) than they did for basic family needs. In the third year, 51 percent of the sample reported that they received help for some aspect of their children's health or development, which is an increase from 29 percent in year 1 and a slight decrease from 56 percent in year 2. As shown in Table 64, more that a third (39%) received help from a program, agency, or professional with a concern about their children's physical health or illness. Less than 10 percent received help for their young children in areas such as language and communication, physical development, eating problems, problems paying attention, and problems learning new things. Of mothers with children older than 5 years, 22 percent said they received help for concerns related to doing homework.

Table 63. Satisfaction with Services for Basic Needs[a]

Service Area	% Very Satisfied		
	Year 1	Year 2	Year 3
Translating things into English	--[b]	96	100
Parenting information	92	97	98
Paying rent or bills	85	83	98
Dental care	86	93	96
Family planning or birth control	--[b]	90	96
Clothes for children	94	95	93
Housing	--[b]	87	93
Health care for mother or children	78	86	93
Getting enough food	83	86	92
Transportation	93	97	91
Childcare	78	87	86
Employment	56	74	84
Mental health or substance abuse	49	85	83
Emergency shelter	--[b]	81	81
Legal issues	71	80	77

[a] Only mothers who reported using each service rated their satisfaction level, so *n* differs for each item. Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Item not included in year 1 survey.

Table 64. Help Received for Concerns about Children's Health and Development[a]

Service Area	% Year 1 (*N* = 390)	% Year 2 (*N* = 390)	% Year 3 (*N* = 390)
Children of all ages			
Physical health or illness	22	48	39
Language and communication	4	7	7
Physical development	2	5	3
Problems paying attention	3	2	3
Eating problems	2	4	2
Problems learning new things	2	2	2
Anger: getting upset or angry	1	1	1
Social skills	1	1	1
Sadness, depression, shyness, or withdrawal[b]	1	1	1
Older Children > 5[c]			
Doing homework	12	13[e]	22[g]
Academic progress	--[c]	--[c]	16[g]
School attendance	5[c]	2[e]	2[h]
Older Children > 10[b]			
Use of drugs or alcohol	2[d]	0[f]	2[i]

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] The year 1 survey had two separate items about sadness, depression, shyness, or withdrawal, but these items are combined here.
[c] Sample sizes for items about older children varied year to year depending on the number and age of older children in the households.

Mothers' satisfaction with most child development services was high and, overall, higher in year 3 than in previous years (see Table 65). The only exception was satisfaction with assistance for concerns about older children's school attendance, which dropped from 100 percent responding "very satisfied" in year 2 to 36 percent in year 3.

Table 65. Satisfaction with Child Health and Development Services[a]

Service Area	% "Very Satisfied"		
	Year 1	Year 2	Year 3
All Children			
Physical health or illness	85	92	96
Language and communication	71	81	100
Problems paying attention	55	75	100
Physical development	96	67	89
Eating problems	42	81	96
Problems learning new things	33	76	100
Anger: getting upset or angry	49	81	100
Social skills	54	100	100
Sadness, depression, shyness, or withdrawal	--[b]	100	100
Sadness or depression	93	--[b]	--[b]
Shyness or withdrawal	45	--[b]	--[b]
Older Children > 5			
Doing homework	87	85	88
Academic progress	--[c]	--[c]	94
School attendance	93	100	36
Older Children > 10			
Use of drugs or alcohol	100	NA	100

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Items about sadness, depression, shyness, or withdrawal were worded differently across the three years.
[c] The sample sizes for items about older children varied year to year because of the number and age of older children in the households.

Service Use by TGA

As shown in Table 67, a larger percentage of mothers in the Glades TGA group than mothers living in the non-Glades TGAs or outside the TGAs reported that they received services in five or more areas during the previous year. In terms of specific areas of service use, larger percentages of Glades mothers than mothers in the other two groups received help meeting the basic needs of their families in most areas. The exceptions were in the areas of family planning and translating things into English. These differences in service use might reflect some of the characteristics that differentiate the three samples as well as variations in the availability of services in these communities. Because a larger percentage of mothers in the non-Glades TGAs were foreign-born and did not speak English as their primary language, it may be more difficult for them to get information about available services or to find services in their own languages. The fact that more mothers in the non-Glades TGAs reported they do not drive or that transportation was not easy for them also suggests that they may have

more difficulty accessing services. These and other barriers to service use will be discussed in more detail later in this report.

Table 66. Number of Service Areas Used by Mothers in Glades and Non-Glades TGAs by Year[a]

Number of Service Areas Used*	Year 1			
	% All Mothers (*N* = 390)	% Glades (*n* = 50)	% Non-Glades TGA (*n* = 339)	
0 to 2	37	18	40	
3 or more	63	82	60	
	Year 2			
	% All Mothers (*N* = 390)	% Glades (*n* = 49)	% Non-Glades TGA (*n* = 316)	% Outside TGAs (*n* = 24)
1 or 2	24	12	24	50
3 or more	76	88	76	50
	Year 3			
	% All Mothers (*N* = 390)	% Glades (*n* = 48)	% Non-Glades TGA (*n* = 303)	% Outside TGAs (*n* = 39)
0 to 2	38	22	42	34
3 or more	62	78	58	66

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
**Chi-square tests indicated statistically significant differences between Glades and non-Glades mothers in year 1 ($\chi^2 = 13.493$ $p < .004$); differences between Glades, non-Glades, and outside TGA mothers in year 2 ($\chi^2 = 23.545$, $p < .001$).; and between Glades, non-Glades, and outside TGA mothers in year 3 ($\chi^2 = 19.809$, $p < .003$).

Table 67. Use of Specific Services by Mothers in Glades and Non-Glades TGAs at Year 3[a]

Type of Service	% All Mothers (*N* = 390)	% Glades (*n* = 48)	% Non-Glades TGA (*n* = 303)	% Outside TGAs (*n* = 39)
Health care for mother or children	92	96	92	90
Getting enough food	70	83	68	64
Family planning or birth control	30	23	30	33
Dental care	26	38	24	28
Childcare	23	47	20	18***
Parenting information	12	25	10	8**
Paying rent or bills	8	16	7	8
Housing or emergency shelter	8	10	8	5
Translating things into English (*n* = 199)	7	0	8	0
Transportation	6	17	5	3**
Housing	7	10	7	5
Legal issues	5	6	5	5
Employment	4	10	3	3*
Clothes for children	3	2	3	3
Mental health or substance abuse	3	2	3	3
Emergency shelter	1	2	1	0

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
Chi-square tests indicated that differences between Glades, non-Glades, and outside TGA mothers are statistically significant at *$p \leq .05$ or **$p \leq .01$ or ***$p \leq .001$.

Reported Service Providers in Year 3

As in previous years, mothers reported receiving help for their concerns from an extensive group of agencies, programs, and professionals in the third year. Table C-1 in Appendix C lists the most frequently mentioned providers for health care, other basic needs, and concerns about children's development. These data should be interpreted cautiously in light of last year's findings on the reliability of mothers' self-reports of names of providers. When we compared mothers' reports on use of Healthy Beginnings agencies with administrative data, we found a number of inconsistencies between the survey and administrative data. Not surprisingly, the administrative data showed higher use of specific agencies than the survey data. Although the survey data seemed to reflect the frequency with which mothers used various agencies relative to other agencies, they were not accurate in terms of the absolute number of contacts with these providers.[54]

As expected, the most frequently mentioned service providers—Medicaid or KidCare, WIC, the Food Stamp Program, the Department of Children and Families, health clinics and medical doctors, and the Department of Health— were those in the two dominant areas of concern among mothers—health care for themselves or their children and food assistance. The next most frequent providers included Family Central, the administrator of the childcare subsidy system, and private health insurance companies and HMOs (e.g., Humana, Blue Cross Blue Shield, and United Health Care).

Service Needs and Help-Seeking in Year 3

The survey also asked mothers who did not receive help in a particular service area during the previous year if they had had a concern in that area and, if so, whether they had tried to get help for that concern. Their responses are presented in the next two tables. First, Table 68 shows the percentage of the group of mothers who did not get help who said they had a concern in that area. For example, Table 62 shows that 8 percent of the sample did not use health services in the year previous to the third-year interview. Table 68 shows that of the 8 percent who did not receive health services, most (84%) said they had concerns in the area of health. Or, for another example, we know from Table 62 that 77 percent of the sample did not receive assistance with childcare the previous year. Table 68 shows that of that group of mothers, 38 percent sought help in this area.

Thus, Table 68 shows mothers' perceptions of their service needs, with health care as the area mentioned most frequently among mothers not receiving services. The next most frequent areas in which needs for services were not met were childcare, translation services, getting enough food, housing or shelter, and paying rent or bills. Only small percentages of mothers reported not receiving help for needs related to their children's health or development. The largest area of concern was help with children's homework, which was a concern of 12 percent of mothers with school-age children, and children's academic progress, mentioned by 9 percent. Other concerns related to children's development were mentioned by 6 percent or less.

[54] For this reason, we decided to discontinue asking mothers for names of providers (except for childcare providers) in future surveys.

Next, in Table 69, we present the percentages of mothers with concerns in each service area who sought help for their concerns. These results suggest that mothers seek help at different rates depending on the area of service need. That is, mothers with concerns were more likely to seek help in the areas of health care (88%), food (61%), and childcare (54%) than in other areas. They were next most likely to seek help with concerns related to housing (28%) and dental care (28%). The percentages of mothers who had concerns about their children's development and sought help were generally smaller than the percentages who sought help for basic needs. Almost half (46%) sought help when they were concerned about their child's language and communication skills, and more than a third (38%) when they had concerns about older children doing homework, however.

Table 68. Concerns of Mothers Who Did Not Receive Services at Year 1, Year 2, and Year 3[a]

Service Area	% Year 1[b]	% Year 2[b]	% Year 3[b]
Health care for mother or children	43	74	84
Childcare	28	30	38
Translating things into English	--[c]	30	38
Paying rent or bills	31	24	32
Getting enough food	29	22	32
Dental care	37	40	30
Housing	23[d]	25	28
Employment	15	11	16
Transportation	20	16	15
Child's homework: older child > 5	--[c]	--[c]	12
Clothes for children	15	13	11
Legal issues	11	9	11
Child's language and communication			6
Family planning or birth control	--[c]	9	5
Reading or writing skills	--[c]	8	5
Child's anger issues			5
Child's attention problems			4
Emergency shelter	--[c]	9	3
Parenting information	13	5	3

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Percentage of mothers who did not receive help and who said area was a concern.
[c] Items were not included in these surveys.
[d] In year 1, housing was combined with emergency shelter.

These year 3 results are both similar to and different from the concerns and help-seeking of mothers reported in the first and second year. For example, across the 3 years, most mothers sought help when they had a concern about health care for themselves or their children, and at least half sought help when they had a concern about getting enough food. There was a modest increase in help seeking for concerns about children's physical development, language and communication, and childcare in the third year relative to the first 2 years. On the other hand, there was a decrease in help seeking for concerns about children's physical health or illness and older children doing homework.

Table 69. Mothers Who Sought Help for Concerns at Year 1, Year 2, and Year 3[a]

Service Area	% Year 1[b]	% Year 2[b]	% Year 3[b]
Health care for mother or children	87	100	88
Getting enough food	51	40	61
Childcare	36	49	54
Child's language and communication	30	29	46
Child's homework: older child > 5	0	62	38
Housing	--	41	28
Dental care	27	28	28
Paying rent or bills	32	31	21
Reading or writing skills	--	14	20
Employment	17	29	17
Child's attention problems	23	32	16
Parenting information	50	12	14
Family planning or birth control	--	40	10
Child's anger issues	18	10	9
Emergency shelter	--	21	8
Legal issues	28	19	8
Transportation	17	16	2
Translating things into English	--	7	2
Clothes for children	7	17	1

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Percentage of mothers who sought help for a concern.
[c] Item not included in survey.

Mothers' Perceptions of Reasons Services Not Received

When mothers reported they did not receive help they sought, they were asked why. As shown in Table 58, many of the reasons were related to program or provider limitations. Most often, mothers said they were told they were not eligible for help when they applied for services because they did not meet the income threshold, did not live in the service area, or some other reason. In some cases, mothers were eligible for help at the time they applied, but the service was not available, and they were put on a waiting list. This was often the explanation given for not receiving a childcare subsidy. In other cases, mothers were told that services were no longer available (for example, as was the case with Section 8 housing vouchers) or that the agency would not provide a needed service for some other reason. Some, on the other hand, are associated with mothers' characteristics or behaviors: for example, small numbers of mothers reported not following up on referred services, missing appointments, having transportation or childcare problems, or losing their paperwork.

Another category of reasons was that mothers had started or completed an enrollment process and were waiting for services and, thus, were reasonably assured of obtaining the service in the future. These included mothers who had submitted their applications and were waiting for a response and mothers who had an appointment scheduled. Another small group of mothers said they had contacted a service provider but had not received a response.

A third category of reasons related to characteristics of individual mothers that interfered with participating in services for which they might have been eligible, including a lack of follow through or persistence, losing paperwork or not having the necessary paperwork, and having accessibility issues, such as a lack of childcare or transportation or difficulty scheduling an appointment. Some of these reasons, of course, overlap with program and provider factors, such as eligibility requirements and the days and times offices are open.

Later in this report, we present qualitative data to explore in more detail the reasons mothers did not receive services. Often, mothers reported multiple reasons related to provider characteristics that adversely affected their receipt of services. For example, a mother whose child was covered under Medicaid for his first year lost coverage when she reapplied because, she was told, her income from a new job was too high. Medicaid referred her to KidCare, but KidCare staff referred her back to Medicaid. After several months of being bounced back and forth between the two programs, she tired of the situation and stopped applying. At the time of her last interview, no one in the family had insurance of any kind. They reported using a local clinic if they have any medical needs.

Table 70. Reasons Mothers Seeking Help Did Not Receive Services at Year 3[a]

Reason	Frequency	Percent[b]
Mother/children not eligible for services (income too high, not in service area)	112	35
Mother put on waiting list	66	21
Service not available anymore (e.g., no vouchers left, no waiting list)	25	8
In process of getting service (paperwork in process)	22	7
Mother made contact but has not heard back	21	7
Mother did not follow up, missed appointment, no longer interested, or frustrated and gave up	13	4
Mother sought help for area of concern, but agency did not cover	12	4
Mother lost paperwork or did not have necessary papers	11	3
Mother received response from provider but still has a concern	11	3
Accessibility (childcare, transportation, or scheduling difficulty)	10	3
Mother has not received help yet but has appointment scheduled	4	1
Language barrier	4	1
Service too costly	3	1
Mother unable to contact service	2	1

[a] Data were weighted to adjust for oversampling of mothers from the Glades and mothers screened "at risk."
[b] Percentage of all reasons *(N* = 320).

Summary

Information on service use came from both mothers' self-reports and FOCiS administrative data on the Healthy Beginnings system. Administrative data indicated that among mothers in the 2004-2005 TGA birth cohort, less than half (40%) received services from Healthy Beginnings. The population targeted by the system, including mothers who were teens, were unmarried, had less than a high school education, were Hispanic, or were foreign-born, were more likely to receive services than other mothers. Twice as many mothers in the year 3 study sample (80%) received services from Healthy Beginnings around the birth of the focal child, with more services occurring after the child's birth than before. Most of these services were provided during the 3 months before and the 6 months after the birth of a child.

With regard to other services, most (96%) of the sample reported receiving help from at least one program, agency, or professional in the past year for help meeting basic family needs. The average number of service areas in which mothers received help for basic family needs was two, which was lower than the average number of services reported in years 1 and 2. Consistent with previous years of the study, mothers in the third year reported receiving help most often with health care and food. Less than a third of the sample received help with any other area of service use, with family planning, dental care, and childcare the next most frequent areas in which mothers reported receiving assistance.

We also found that mothers tended to seek help at different rates depending on the area of service need. Mothers with concerns were more likely to seek help in the areas of health care (88%), food (61%), and childcare (54%) than in other areas. They were next most likely to seek help with concerns related to housing (28%) and dental care (28%). The percentages of mothers who had concerns about their children's development and sought help were generally smaller than the percentages who sought help for basic needs.

TRENDS AND PATTERNS IN SERVICE USE

This chapter examines mothers' self-reported service use during the year prior to the year 3 interview and compares the levels and patterns of use in this year to that occurring in the years prior to the first two interviews.[55] In order to focus the analysis on the major categories of service use, we combined several service categories into one and/or used reports of public income supports to help define service categories. Specifically, mothers who reported receiving help with health care for themselves or their children, or help with a child's physical health or illness, were coded as receiving help in the general area of health care for their family. Also, mothers who reported receiving help with getting enough food or who reported receiving either WIC or food stamps were coded as receiving help in the general area of food. Third, mothers who reported receiving help with paying their rent or bills or who reported receiving help with their rent from a voucher program were coded as receiving help in the general area of rent or bills. Finally, mothers who reported receiving help with their child's physical development, language and communication, or behavioral or emotional development were coded as receiving help in the broader area of child development.

Trends in Service Use

Table 71 shows the percentage of mothers in each survey year that reported receiving help in the aforementioned broad categories, as well as help with other major categories of service use. It shows that, in all three survey years, a majority of mothers reported receiving help with health care for their families and with food assistance. In addition, a majority of mothers received help with parenting information in the 12 months prior to survey year 1. Also, approximately a quarter or more of mothers received help with family planning and dental care in years 2 and 3, with parenting information in year 2, and with childcare in year 3.

There was a significant decline in reported help getting enough food between years 2 and 3 ($F = 49.2$, $p < .001$). This finding is not surprising, given the results in Table 5 showing a decline in use of the two major sources of food assistance, the Food Stamp and WIC programs, from year 2 to year 3. Compared with mothers who stopped receiving food assistance, mothers who maintained food assistance received significantly ($p \leq .05$) more days of intensive care coordination (12.1 vs. 7.2 days) and were more likely to be Hispanic (59% vs. 45%), have income at or below the poverty line (80% vs. 57%), and three or more children at the time of the baseline survey (30% vs. 17%). These mothers also had significantly lower family/friend support scores (9.0 vs. 10.5) and were less likely to have post-secondary education (11% vs. 30%) or to be U.S.-born (38% vs. 55%). In addition, mothers who continued to receive food assistance were less likely to have worked in the second year of the study than mothers who stopped receiving food assistance (35% vs. 65%). Thus, it appears that, on a number of measures, those who were more likely to be in need of assistance with getting enough food were able to continue receiving such assistance.

Our data do not provide enough details on the timing of employment in relation to receipt of food assistance, so the reasons for the link between mothers' work status and the decline in

[55] Throughout the text, service use that occurs in the 12 months prior to survey year 1, for example, will be referred to as service use that occurred in or during year 1.

receipt of food assistance are not clear. One reason might be that mothers having difficulties obtaining food assistance feel pressured to seek employment. Alternatively, job changes may lead to improvements in family income level that affect mothers' eligibility for food assistance. When Debra, a single mother, went to work full-time as a corrections officer trainee in the local prison about a year after she gave birth, she was no longer eligible for WIC or food stamps. Or, mothers may not have accurate information about their eligibility for food assistance. Silvia, a 19-year-old mother from Guatemala, said she would only apply for food stamps if she were not working because "they say they only give them to those who are not working." As we discuss in more depth later in this report, the qualitative data suggest several other reasons for the decline in use of food assistance, including mothers' perceptions of need, alternative sources of help, and the benefits received in relation to the application costs in terms of time, transportation expenses, and obligation to share personal information. There is also evidence that the recertification process for public benefits can be onerous for some mothers in the context of their daily routines; if they miss an appointment to file for recertification, benefits may lapse.

Table 71. Patterns of Service Use in 12 Months Prior to Survey Years 1-3[a]

Service Area	Year 1 (*n* = 385)	Year 2 (*n* = 384)	Year 3 (*n* = 387)
	%	%	%
Health care for family	75	95	93
Food	90	88	70
Family planning	--[b]	36	30
Dental care	19	24	25
Childcare	14	20	23
Child development	9	13	13
Parenting information	70	23	12
Rent or bills	11	10	9
Housing	4	8	8
Transportation	17	14	6
Legal	2	2	5
Employment	4	6	4
TANF	6	6	3
Children's clothing	6	5	3
Mental health/substance abuse	2	2	3
Mean (*SD*) of items common across years	3.3 (1.6)	3.2 (1.7)	2.8 (1.7)

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] Family planning was not included in the year 1 survey and is not included in the calculation of the mean.

For some mothers, food was a necessity that—unlike health care—they were responsible for providing for their children; if they were unable to do so or lost their public assistance, they were likely to turn to family members or other informal resources for help. When Tania was asked how she would manage without her monthly food stamps, she responded: "I manage, very easy. Trust me if I couldn't manage, I would find me a church or something where I could get food from. They are not going hungry and that is why [my cousin] and Fiona's daddy is alive. We are going to be all right." Some mothers were willing to put up with the application process

to receive food assistance even though it required, in the words of one mother, too much "meddling in your business," because "if you need the help you got to do whatever it takes." Other mothers said they chose not to apply or reapply for food stamps because it would require them to file for child support against their partners who were providing regular help for them and their children. Denise, a 20-year-old mother of two children, explained: "If he wasn't doing what he was doing, then I would [file for child support]. But he is taking care of him, so I give him that credit."

Still other mothers stopped receiving food assistance because they missed a follow-up appointment and were unable to reschedule before their benefits were cut off. Teresa, a 28-year - old Hispanic mother of two children, missed an appointment at the WIC office when she forgot about it. She was told someone would call her to reschedule, but she never received a call. She subsequently obtained food stamps and decided not to reapply to WIC because she did not believe she could receive both kinds of assistance at the same time, and because what she would pay in transportation costs was much more than what it would cost her to provide the milk and other food items herself: "I have to pay a taxi, $30 from here to Lantana. It's better that I just pay for the milk."

There was also a significant decline in the percentage of mothers who reported receiving help with parenting information between years 1 and 2 and between years 2 and 3. Comparison of the mothers who received such help in years 2 and 3 with those who stopped receiving it during this time showed that mothers in the former group were significantly less likely ($p \leq .05$) to have lived with a husband or partner in year 1 (36% vs. 63%) and had significantly lower partner support scores (6.3 vs. 9.9). Comparison of the mothers who received parenting information help in years 1 and 2 with those who ceased receiving it during this time did not reveal any statistically significant differences between the two groups.

The qualitative interview data suggest that one reason for the decline is that mothers increasingly turned to other sources, including their informal support networks, for parenting information. For example, Juanita, a 27-year-old Mexican immigrant who is married with one child, said that her primary source of advice is her mother, who is still in Mexico; she calls her every other week. When asked what kind of advice she asked her mother for, she responded: "For instance, when they don't behave, my mom tells me to have patience because that is how kids are. Little by little they will understand." Her husband's relatives who live close by are another source of support and information, and she knows that when her daughter is ready for school, she can ask them for advice: "When she turns 5, we are going to ask his aunt [about school]."

Norma, a 22-year-old, native-born mother of one child, said that during the first year after her child was born she would get advice on child-rearing from her mother, her friends, and other family members, as well as from watching them raise their children.

> I see them go through a lot of things. They're like "Don't do this. Don't let him be outside with no shoes, no clothes." I usually used to see it all when I was growing up. It's like, "Oh." One of my friends would always … when I was bathin' the

> baby in the tub when he was startin' to get in the tub, she like, "No, don't do that. Don't let the water go near here."

But now, she said, she was more likely to get information from books and her son's childcare center. She particularly values the checklist of developmental skills the center asks her to fill out on her child's progress:

> But now, I don't get advice from [my friends]. I usually read to try to actually see if my baby's doing what he supposed to be doing at the age he's at. And at the day care they always give me the little studies that they're doing [the Ages & Stages Questionnaire], like a little survey, and it has like motor skills and [other] skills that they supposed to do. And it ask questions, and every question you have to do a activity or somethin' with the child, and if he's doing it at that age, you write a certain number. It's either a 10, a 5, or a 0. Then it'll add up and see if he's doin' good at his age. I like that too. They send those surveys home, then you take them back to them.

Service Use Patterns and Their Correlates

The bottom of Table 71 shows that the average number of services used by mothers declined from 3.3 in year 1 to 2.8 in year 3. This difference is statistically significant ($F = 27.30$, $p < 0.001$). In addition, the decline in average service use between years 2 and 3 is also significant ($F = 20.81$, $p < 0.001$).

Table 72 provides further information about the number of services used by dividing mothers into four categories corresponding to no service use, and use of one to two, three to four, and five or more services. This table shows that the decline in numbers of services used between years 1 and 3 arises primarily from an increase in the percentage of mothers using one to two services, and a decline in the percentage using three to four services. The size of the group of mothers using five or more services remains fairly constant and although the percentage of mothers using no services increases, the overall number in this group remains small.

Table 72. Number of Services Used, by Year[a]

Number of Services	Year 1 (n = 385)	Year 2 (n = 389)	Year 3 (n = 387)
	%	%	%
0	1	0	4
1-2	30	41	50
3-4	51	42	32
5+	17	17	15
Mean (*SD*)***	3.3 (1.6)	3.2 (1.7)	2.8 (1.7)

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
ANOVA analyses indicate the difference between the mean services used in year 2 and year 3 and between year 1 and year 3 are statistically significant at ***$p < 0.001$.

Table 73 shows how patterns of service use in year 3 differed across the three groups of mothers who used one or more services. It shows that the vast majority of mothers in all three groups received help with health care for their families. In addition, large majorities of mothers in the groups using three to four and five or more services also received help with getting enough food, whereas about half of the mothers using one to two services received such help. Among mothers using three to four services, smaller but still substantial proportions received help with family planning (45%), dental care (30%), and childcare (26%). Among mothers using five or more services, the most prevalent areas of service use besides health care and food were help with dental care (60%), family planning (58%), childcare (56%), parenting information (44%), child development (39%), rent or bills (36%), housing (32%), and transportation (25%). Fewer than 1 in 6 mothers using five or more services reported receiving help with obtaining legal services, employment, clothing, mental health or substance abuse services, reading/writing, or using TANF.

Table 73. Service Use Categories in Year 3, by Number of Services Used in Previous Year[a]

Service Category	Number of Services			
	0	**1-2**	**3-4**	**5+**
	%	%	%	%
Health care for family	--	92	100	99
Food	--	48	86	95
Dental	--	6	30	60
Family Planning	--	4	45	58
Childcare	--	6	26	56
Parenting information	--	3	5	44
Child development	--	0	14	39
Rent/bills	--	1	5	36
Housing	--	0	5	32
Transport	--	0	4	25
Legal	--	1	4	15
TANF	--	0	1	14
Employment	--	1	4	9
Clothing	--	0	3	9
Mental health/substance abuse	--	0	4	8
Reading/writing	--	0	0	2

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

How do mothers using different numbers of services differ from one another? Table 74 addresses this question by comparing the baseline and year 2 characteristics of mothers in each number of services category in year 3. Pairwise *z*-tests of percentages and pairwise *t*-tests of means revealed that mothers using five or more services were significantly more likely ($p \leq .05$) than those using either one to two or three to four services to be born in the United States, be Black, have a child (other than the target child) with special medical needs, and have one or more investigated DCF reports. They also had received a significantly higher number of days of intensive care coordination. In addition, these mothers were significantly less likely than mothers in the other two groups to be Hispanic. They were also significantly more likely than

Table 74. Mothers' Baseline and Year 2 Characteristics by Number of Services Reported at Year 3

	Group 1 0 Services	Group 2 1-2 Services	Group 3 3-4 Services	Group 4 5+ Services
Baseline Characteristics				
Glades (%)	0	9	15	18
U.S.-born* (%)	42	39	38	62
Black, not Hispanic* (%)	58	32	32	56
Hispanic* (%)	18	62	61	37
Education				
HS grad (%)	37	26	20	29
Post-HS (%)	24	18	15	18
Teen mother at focal child's birth (%)	21	22	18	13
Healthy Beginnings services				
Days of care coordination	6.7	4.2	5.2	4.6
Days of intensive care coordination*	8.5	6.7	10.7	16.5
Study risk index	4.4	3.5	3.7	3.6
Year 2 Characteristics				
Number of children				
One* (%)	61	52	40	24
Two (%)	18	34	32	35
Three or more* (%)	21	14	28	40
Lives with husband or partner* (%)	33	74	68	57
Mother employed (%)	73	49	44	37
Income-to-need ratio at or below poverty* (%)	34	48	55	71
Own home (self or household member) (%)	27	26	23	23
Target child—special needs (%)	9	19	16	29
Other children—special needs* (%)	0	6	9	22
Mother has physical or mental health problem (%)	9	6	3	9
Other household member has health problem* (%)	24	5	7	15
Partner support score	5.9	9.7	9.8	8.6
Family/friend support score	8.3	7.9	9.1	8.9
Depression: CES-D score $\geq$ 16 (%)	27	18	28	27
Stress: PSI/SF score $\geq$ 86 (%)	30	12	19	17
Investigated DCF report(s) from birth to age 1 year* (%)	0	6	7	22
Indicated DCF report(s) from birth to age 1 year (%)	0	4	4	12

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

*Denotes variable for which one or more pairwise comparisons between groups were statistically significant ($p \leq .05$). The following group (in parentheses) differences were statistically significant at this level: U.S.-born (2) vs. U.S.-born (4), U.S.-born (3) vs. U.S.-born (4); Black (2) vs. Black (4), Black (3) vs. Black (4); Hispanic (1) vs. Hispanic (2), Hispanic (1) vs. Hispanic (3), Hispanic (2) vs. Hispanic (4), Hispanic (3) vs. Hispanic (4); days intensive care (2) vs. days intensive care (4), days intensive care (3) vs. days intensive care (4); one child (1) vs. one child (4), one child (2) vs. one child (4); three or more children (2) vs. three or more children (3), three or more children (2) vs. three or more children (4); lives with husband/partner (1) vs. lives with husband/partner (2), lives with husband/partner (1) vs. lives with husband/partner (3); in poverty (1) vs. in poverty (4), in poverty(2) vs. in poverty (4); other child—special needs (2) vs. other child—special needs (4), other child—special needs (3) vs. other child—special needs (4); HH member—health problem (1) vs. HH member—health problem (2); investigated DCF reports (2) vs. investigated DCF reports (4), investigated DCF reports (3) vs. investigated DCF reports (4).

mothers using one to two services to have incomes at or below the poverty level and to have three or more children, and they were significantly less likely to have only one child.

Table 74 also shows that there were some substantive differences between the small number of mothers using no services and those in one or more of the other categories. Pairwise *z*- and *t*-tests revealed that mothers using no services were significantly less likely than mothers using either one to two or three to four services to be Hispanic or to be living with a husband or partner ($p \leq .05$). This group was also more likely than those using one to two services to be living with a household member with a health problem. Lastly, these mothers were less likely than those using five or more services to have incomes at or below the poverty level, and more likely to have only one child. The only significant difference between mothers using one to two versus three to four services was that mothers using one to two services were less likely to have three or more children.

Finally, we conducted a regression analysis in order to determine which variables continue to be significantly associated with greater service use, after taking into account possible correlations between them. The primary variables selected for the regression were those that were statistically significant in Table 74. In addition, the indicator for residence in the Glades TGA was included because it may be of special interest as a background variable. Also, the race and nativity variables were combined in order to determine whether there were significant differences in service use among U.S.-born Blacks and Hispanics, foreign-born Blacks and Hispanics, and mothers falling into the "other" category.[56] The results of the regression analysis are presented in Table 75.

The regression analysis shows that many of the variables that were significant in Table 74 remain so after controlling for the other variables; however, the size of the coefficients indicate quantitatively small differences in service use between different groups of mothers. The largest statistically significant differences were found between U.S.-born Blacks and foreign-born Hispanics, and between mothers with only one child and those with three or more children. However, in both cases, the estimated coefficients indicate that the difference in service use between the groups was only about one service on average. The coefficients for foreign-born Blacks, mothers with two children, employed mothers and those with non-target children with special needs were also significant. The results for the first three variables indicate that these mothers used about half a service less than mothers in the respective comparison groups, whereas mothers with children with special needs used about half a service more. Lastly, the coefficient on days of intensive care coordination indicated that a one-standard-deviation increase in the number of days of intensive care coordination (or about 18 days) was associated with use of an additional quarter of a service.

[56] The other category consists of mothers who were identified as White, Asian, or some other race/ethnic group. There were not enough of these mothers to divide them into U.S.- and foreign-born.

Table 75. Regression Analysis of Number of Services Used in Year 3

Predictor Variable	Coefficient	Sig.
Glades	.341	*NS*
Race/nativity:		
Black—U.S.-born	.882	**
Black—foreign-born	-.570	^
Hispanic—U.S.-born	-.185	*NS*
Hispanic—foreign-born (excluded category)	--	--
White/other	-.039	*NS*
Days of intensive care coordination	.014	**
Lived with husband or partner (year 2)	-.186	*NS*
Number of children (year 2):		
One	-.904	**
Two	-.469	*
Three (excluded category)	--	--
Mother employed (year 2)	-.513	**
Income at or below poverty (year 2)	.191	*NS*
Other children—special needs (year 2)	.573	*
Investigated DCFreport(s) birth to age 1 year	.392	*NS*
Constant	3.44	**
R^2	.26	

^ $p < .10$, * $p < .05$, ** $p < .01$.

Changes in Service Use at the Individual Level

Table 71 presented information on changes in service use at the aggregate level. However, it is also important to have an understanding of changes in service use at the individual level. Accordingly, Table 76 shows the percentages of mothers who either increased or decreased their service use by two or more services between each survey year. The table shows that 10 to 15 percent of mothers increased their service use between years 1 and 2 and years 2 and 3, while somewhat larger percentages (20%-22%) decreased their service use. Overall, between years 1 and 3, twelve percent of mothers increased service use while more than twice as many decreased service use. The table also shows that, for both years 1 and 2, the initial average number of services used by mothers who increased service use was considerably less than the initial average number of services used by mothers who decreased service use.

Tables 77 and 78 highlight patterns of service use among mothers who reduced their service use between years 2 and 3, and between years 1 and 3, respectively. Table 77 (?) suggests that mothers' reduction in use of services was distributed widely across the different service use categories, as opposed to being concentrated in a few categories. Thus, statistically significant declines ($p \leq .05$) were observed in all categories except legal services and mental health/substance abuse. In terms of percentage declines, however, the largest decreases were seen in receipt of TANF and use of help obtaining parenting information, employment, transport,

housing, and child development. Similarly, Table 78 (?) shows that mothers' reduction in service use between years 1 and 3 was also distributed widely across categories of service use, although somewhat fewer categories showed statistically significant declines between the two years.

Table 76. Percentage of Mothers Experiencing Change of Two or More Services across Years[a]

	Increased by 2 or More Services	Decreased by 2 or More Services
Year 1 to Year 2		
% of mothers	15	20
Mean number services in year 1	2.5	4.8
Mean number services in year 2	5.1	2.3
Year 2 to Year 3		
% of mothers	10	22
Mean number services in year 2	2.7	4.9
Mean number services in year 3	5.2	2.2
Year 1 to Year 3		
% of mothers	12	27
Mean number services in year 1	2.5	4.5
Mean number services in year 3	5.3	1.9

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

Table 77. Patterns of Service Use among Mothers Reducing Use between Years 2 and 3[a]

Service Area	Year 2	Year 3
	%	%
Health care for family*	98	83
Food*	98	56
Parenting information*	53	7
Dental care*	42	17
Family planning*	39	26
Childcare*	35	15
Transportation*	30	6
Child development*	29	7
Housing*	26	6
Rent or bills*	22	8
Employment*	21	4
TANF*	15	2
Children's clothing*	12	4
Legal	7	6
Mental health/substance abuse	3	2
Reading/writing	0	0

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
*Pairwise *t*-tests indicate difference between years 2 and 3 is significant ($p \leq .05$).

Table 78. Patterns of Service Use among Mothers Reducing Use between Years 1 and 3[a]

Service Area	Year 1	Year 3
	%	%
Health care for family	89	82
Food*	94	46
Parenting information*	84	5
Dental care*	41	14
Family planning	--[b]	22
Childcare	22	13
Transportation*	27	4
Child development*	21	5
Housing	6	6
Rent or bills*	19	7
Employment*	10	0
TANF*	14	1
Children's clothing*	14	2
Legal	5	3
Mental health/substance abuse	3	3
Reading/writing	--[b]	0

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
[b] The year 1 survey did not inquire about help received with family planning or reading/writing.
*Denotes significant difference between years 2 and 3 ($p \leq .05$).

Table 79 provides information on the baseline and year 1 characteristics of mothers who either decreased or increased service use by two or more services between years 2 and 3 and compares these mothers with those who did not experience a substantive change in service use. As was suggested in Table 6, the number of mothers who experienced a substantive change in service use was small relative to the number of mothers who experienced little or no change; this was particularly true with respect to mothers who experienced an increase in service use. Pairwise *z*-tests of percentages and pairwise *t*-tests of means in Table 59 indicated that mothers who decreased service use were significantly more likely ($p \leq .05$) than mothers with little or no change in service use to have the following characteristics: U.S.-born (57% vs. 38%), non-Hispanic Black (50% vs. 32%), living with a household member who had a health problem (19% vs. 9%), more days of intensive care coordination (16 vs. 8), and a depression score equal to or greater than 16 (43% vs. 28%). The latter three results suggest that, for unexplained reasons, mothers who appeared to have more needs were more likely to experience a reduction in service use. Finally, mothers who decreased service use were also significantly less likely than those with little or no change to be Hispanic (39% vs. 62%).

Table 79. Baseline and Year 1 Characteristics of Mothers Who Changed/Did Not Change Service Use between Year 2 and Year 3[a]

Baseline Characteristics	Group 1 Decreased Service Use[b] (*n* = 77)	Group 2 No (or Little) Change in Service Use (*n* = 251)	Group 3 Increased Service Use[b] (*n* = 36)
Glades (%)	18	12	13
U.S.-born* (%)	57	37	57
Black, not Hispanic* (%)	51	32	52
Hispanic* (%)	39	62	42
Education			
HS grad (%)	31	23	23
Post-HS (%)	22	15	24
Teen mother (%)	21	19	15
Healthy Beginnings services			
Days of care coordination	5.4	4.6	4.4
Days of intensive care coordination*	15.5	8.4	12.4
Study risk index	3.6	3.6	3.5
Year 1 Characteristics			
Number of children			
One (%)	51	45	30
Two (%)	30	29	32
Three or more (%)	19	26	39
Lives with husband or partner (%)	57	69	69
Mother employed (%)	13	13	13
Income at or below poverty (%)	74	70	75
Own home (%)	28	17	16
Target child special needs (%)	10	8	14
Other children special needs (%)	16	9	12
Mom has physical or mental health problem (%)	9	3	10
Other household member has health problem* (%)	18	8	7
Depression: CES-D score $\geq$ 16* (%)	45	28	45

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."

[b] Indicates mothers who decreased or increased service use by two or more services.

*Denotes variable for which one or more pairwise comparisons between groups were statistically significant ($p \leq .05$). The following group (in parentheses) differences were statistically significant at this level: U.S.-born (1) vs. U.S.-born (2); Black (1) vs. Black (2), Black (2) vs. Black (3); Hispanic (1) vs. Hispanic (2); days intensive care (1) vs. days intensive care (2); other household member—health problem (1) vs. other household member—health problem (2), depression $\geq$ 16 (1) vs. depression $\geq$16(2).

Table 79 also shows some substantive differences between mothers who increased service use and those who experienced little or no change, particularly with respect to nativity, race, number of children, and depression. There were also some differences between those who increased use and those who decreased use, particularly with respect to number of children and living with a household member with a health problem. However, probably due in part to the small number of mothers in the former group, the only statistically significant difference ($p \leq$ .05) was that those who increased service use were more likely than those with little or no change to be Black. Additional pairwise comparisons did indicate that mothers who increased

service use were significantly more likely, at the 10-percent level, than those with little or no change in service use to have a depression score of 16 or higher. In addition, at this significance level, the mothers who increased service use were also more likely than those who decreased services to have three or more children.

We conducted a regression analysis in order to determine which variables continue to be significantly associated with changes in service use, after taking into account possible correlations between the explanatory variables. Specifically, we estimated a generalized ordinal logistic regression, which provides two sets of estimates. The first set of estimates shows how the log odds of a mother falling into either group 2 (no/little change in service use) or group 3 (increased service use) versus group 1 (decreased service use) change as each explanatory variable changes. The second set of estimates shows how the odds of a mother falling into either group 1 or 2 versus group 3 change.[57] The primary variables selected for the regression were those that were statistically significant in Table 9. In addition, the indicator for residence in the Glades TGA was included because it may be of special interest as a background variable.

The results of the regression analysis are presented in Table 80. Statistically significant effects ($p \leq .05$) were found for mothers with one child, mothers living with a household member with a health problem, and total days of intensive care coordination. The estimated odds ratio for mothers with one child indicates that the odds of these mothers being in group 2 (little/no change in service use) or group 3 (increased service use) versus group 1 (decreased service use) are reduced by about .60 compared with the odds for mothers with three or more children. The same applies to the odds of these mothers being in group 3 versus groups 1 or 2. Similarly, the estimated odds ratio for mothers living with household members with a health problem indicate that the odds of these mothers being in groups 2 or 3 versus group 1 are reduced by half, compared with mothers who do not live with a household member with a health problem. Also, the odds of these mothers being in group 3 versus groups 1 or 2 are reduced in the same way, relative to the comparison mothers.

We also found statistically significant effects at the 10-percent level for Black U.S.-born mothers and for mothers with two children. The results indicate that Black U.S.-born mothers were more likely than Hispanic foreign-born mothers to be in group 3 versus groups 1 or 2. Also, mothers with two children were less likely to be in one of the higher categories (i.e., groups 2 or 3), compared with mothers with three or more children.

Table 81 compares the baseline characteristics of mothers who increased or decreased service use by two or more services between years 1 and 2 with the characteristics of those with no or smaller changes in service use.[58] It shows that mothers who increased their use of services were significantly more likely ($p \leq .05$) than those with little or no change in services to be U.S.-born and to be Black. They were also significantly less likely to be Hispanic. These mothers were also significantly more likely ($p \leq .10$) than mothers who decreased services to be Black.

[57] For some variables the two sets of estimates will be equal, implying that the effects of these variables have the same effect on the odds of moving from one category (or set of categories) to another, no matter which category (or set of categories) you start with.

[58] Characteristics at the time of the first survey are not included in this table because these variables might have been influenced by service use occurring prior to the year 1 interview.

Table 80. Generalized Ordinal Logit Analysis of Change in Service Use between Years 2 and 3

Predictor Variable	Estimated Odds Ratio of Falling Above	
	Group 1	Group 2
Glades TGA	.642	.642
Race/nativity:		
Black—U.S.-born	.680	2.11^
Black—foreign-born	.613	.613
Hispanic—U.S.-born	1.05	1.05
Hispanic—foreign-born (excluded category)	--	--
White/ other	.581	.581
Number of children (year 1):		
One	.581*	.581*
Two	.596^	.596^
Three (excluded category)	--	--
White/household member—health problem (year 1)	.500*	.500*
Depression: CES-D score ≥ 16 (year 1)	.686	1.54
Days of intensive care coordination	.984**	1.00
$\chi^2(13)$	45.3	
Pseudo R^2	.06	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Table 81. Baseline Characteristics of Mothers Who Changed/Did Not Change Service Use between Year 1 and Year 3[a]

Baseline Characteristics	Group 1: Decreased Service Use (n = 104)	Group 2 No (or Little) Change in Service Use (n = 230)	Group 3 Increased Service Use (n = 43)
Glades TGA (%)	16	11	18
U.S.-born* (%)	47	40	59
Black, not Hispanic* (%)	40	33	56
Hispanic* (%)	50	60	39
Education			
HS grad (%)	28	20	36
Post-HS (%)	18	16	21
Teen mother (%)	23	19	11
Healthy Beginnings services			
Days of care coordination	5.01	4.73	4.07
Days of intensive care coordination	10.77	9.86	12.05
Study risk index	3.73	3.66	3.41

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
*Denotes variable for which one or more pairwise comparisons between groups were statistically significant ($p \leq .05$). The following group (in parentheses) differences were statistically significant at this level: U.S.-born (2) vs. U.S.-born (3); Black (2) vs. Black (3); Hispanic (2) vs. Hispanic (3).

Overall, there is little evidence to suggest that mothers with greater needs were more likely to increase their use of services between years 2 and 3. In fact, there is some evidence that mothers with greater needs actually reduced their use of services.

Changes in Circumstances and Service Use

It is also of interest to know whether mothers who experience major life changes—such as the birth of a new baby (after the target child) or the dissolution of a relationship—use more, less, or the same number of services as mothers who do not experience such changes. To address this question we examined the proportion of mothers who (1) gave birth to a new baby by the time of the second-year interview; (2) moved twice or more between the first and second interviews; (3) were married at the first-year interview but who were separated or divorced at the second year[59]; (4) were in a relationship at the first-year interview but not at the second year; (5) were employed in the first year but not the second year; (6) had a husband or partner in the first and second years, and whose husband/partner was employed in the first year but not the second; (7) reported a health problem at the second year but not the first year; (8) reported that the target child had special medical needs in the second year but not the first year; and (9) had household incomes below the poverty line at year 2 but not at year 1. We then compared the numbers of services used by mothers in each of these life change groups with the numbers of services used by mothers who could have experienced the life change (for example, were married at year 1 and could have experienced a divorce or separation at year 2) but did not.

Table 82 summarizes this information. It shows that, of the mothers who were in the risk set for experiencing various changes, relatively small percentages (4%-5%) of mothers had a new baby, became divorced or separated, had a husband or partner who lost a job, or developed a health problem. However, somewhat higher percentages broke up with a partner, had a target child who developed special needs, or fell into poverty. In most cases, mothers who experienced a major life change between years 1 and 2 tended to use more services in year 3. Specifically, mothers who had a new baby, ended a relationship, lost employment, had a husband or partner who lost employment, had a target child who developed special medical needs, or fell below the poverty line used more services than the mothers in their respective comparison groups; further, statistically significant ($p \leq .05$) differences were found for mothers who gave birth, moved two or more times, lost a job, or had a target child who developed special needs.[60]

The qualitative data enrich our understanding of how service use is affected by changes in life circumstances. Debra, a 22-year-old single mother of two children, is just one example. When we first met her, she had one child, Justin, who was born in March 2005. Debra, a high school graduate, and her son lived with her mother and one of her brothers in a two-bedroom apartment. Within the first year of her son's birth, she returned to work and eventually landed a full-time evening shift job with the Department of Corrections. Her mother, as well as Justin's

[59] None of the married mothers in the sample were widowed during this time.

[60] Based on these results, we ran another regression analysis of the number of services used in year 3 (see Table 55) that included indicators for giving birth and moving two or more times. (We did not add the other significant variables in Table 62 because they represented changes that could only be experienced by a subsample of the mothers.) Both variables were significant ($p \leq .05$); the estimated coefficients indicated that mothers who had a new baby used 0.9 more services on average, and those who had moved two or more times used 0.8 more services. Moreover, the variables that were statistically significant in Table 55 remained so in the new regression.

father and his mother, helped to care for him while she was working. After 9 months at this job, she was scheduled to receive additional training that would lead to licensure and a higher position in the agency when she discovered she was pregnant again. Her pregnancy meant that she could not participate in the training program, and she subsequently lost her job about a month before her second child was born in June 2007. She was unable to find a new job given the late stage of her pregnancy but was able to get by with the support of her mother and her children's father. Debra told us, "Sometimes things don't work out how they are supposed to work out, so either you try again or you try another solution."

Table 82. Changes in Circumstances between Years 1 and 2 and Numbers of Services Used in Year 3[a]

	Percent of Mothers	Number of Services Used in Year 3
All mothers (n = 386)		
New baby year 2	4	4.42**
Same no. children year 2	96	3.02
Moved 2 or more times year 2	8	4.00**
Moved once or less year 2	92	3.01
Mothers married at year 1 (n = 99)		
Divorced/separated year 2	5	2.73
Still married year 2	95	3.04
Mothers with partner at year 1 (n = 184)		
No partner year 2	23	3.70
Still with partner year 2	77	3.04
Mothers employed at year 1 (n = 51)		
Not employed year 2	10	4.34*
Employed year 2	90	2.58
Mothers with employed husband/partner at year 1 and husband/partner at year 2 (n = 232)		
Husband/partner not employed year 2	5	3.50
Husband/partner employed year 2	95	2.89
Mothers with no health problem year 1 (n = 366)		
Health problem year 2	4	2.25
No health problem year 2	96	3.04
Target child no special needs year 1 (n = 351)		
Target child special needs year 2	16	3.69*
Target child no special needs year 2	84	2.99
Household income above poverty year 1 (n = 107)		
HH income ≤ poverty year 2	23	2.95
HH income > poverty year 2	77	2.58

[a] Data were weighted to adjust for the oversampling of mothers in the Glades and mothers screened "at risk."
* Denotes significant difference ($p \leq .05$) in the mean number of services used.
** Denotes significant difference ($p \leq .01$) in the mean number of services used.

After Justin's birth, Debra received care coordination services twice from the Healthy Start program because a postnatal screen and home assessment indicated she was "at risk," but

then her case was closed. In the first year after Justin's birth, Debra also received Medicaid, WIC, and food stamps. Debra found these services easy to use because of their convenient location in one office complex and simple computer applications. However, by the following year, after she returned to work, she no longer met the income eligibility requirements for WIC or food stamps. She also was having difficulty with her health and health insurance. Along with being pregnant again, she needed a biopsy for a medical condition; but, because she was pregnant, some doctors were not willing to do the biopsy. In addition, she had to wait for a switch to Medicaid from an employer-sponsored insurance program, which had become too expensive for her. This meant starting prenatal care for her second child late. At the time of the third qualitative interview, Debra was the primary caregiver for her two children while she looked for part-time work. Meanwhile, she was receiving unemployment insurance. She also was again eligible for and had reapplied for and was receiving both WIC and food stamps in addition to Medicaid.

Summary

In year 3, as in the previous 2 years, a majority of mothers continued to receive help with health care for themselves and their families, and with getting enough food. Also, across the three years, about the same proportion of mothers—20 to 25 percent—received help with dental care, and similar proportions received help with family planning in years 2 and 3 (30%-36%). Also, compared with year 1, there was a small increase in the proportion of mothers getting help with childcare in year 3.

Although a majority of mothers continued to receive help with getting enough food in year 3, there was a significant decline in this area of help between years 1 and 2 and year 3. However, further analyses suggested that the mothers who continued to receive assistance in this area were those who were more likely to be in need of such assistance. There was also a significant decline between years 1 and 2, and between years 2 and 3, in the proportion of mothers who received help with parenting information. Comparisons of the characteristics of mothers who continued receiving parenting information with those who did not revealed little in the way of significant differences. However, the qualitative interview data suggested that one reason for the decline is that mothers increasingly turned to other sources, including informal support networks, for parenting information.

With respect to the overall number of areas in which mothers received help in the third year, 15 percent of mothers received help in five or more areas, about 1 in 3 received help in three or four areas, half received help in one or two areas, and 4 percent did not receive help in any areas. Bivariate analyses suggested that mothers who used five or more services were more likely to be U.S.-born, be Black, have a child with special medical needs, have incomes at or below poverty, have three or more children, have one or more investigated DCF reports; and have received intensive care coordination services through the Healthy Beginnings system. A subsequent regression analysis showed that U.S.-born Blacks used about one more service on average when compared with foreign-born Hispanics, whereas foreign-born Blacks used about half a service less. Also, mothers with three children were found to use about one service more when compared with mothers with only one child. In addition, employed mothers and those with

two children used about half a service less relative to their respective comparison groups, whereas mothers who had a child with special needs used half a service more.

Between years 1 and 3, a little more than 1 in 10 mothers increased their use of services by two or more, while nearly 3 in 10 reduced their use of services by two or more. Bivariate analyses showed that mothers who decreased their use of services were more likely than those with little or no change in service use to be U.S.-born, be Black, live with a household member with a health problem, and have a high depression score. Thus, there is some evidence that mothers with more needs were more likely to experience a reduction in service use. There were also some substantive differences between mothers who increased their service use and those with little or no change; however, due partly to the small size of the former group, the differences were not found to be statistically significant. Finally, a regression analysis indicated that mothers with fewer children were less likely to increase their use of services, but the same was true of mothers living with a household member with a health problem. In addition, the analysis suggested that U.S.-born Blacks were more likely to increase their use of services relative to foreign-born Hispanics.

Lastly, we found that mothers who experienced a major life change between year 1 and year 2 tended to use more services in year 3. Specifically, we found statistically significant differences in service use for mothers who gave birth, moved two or more times, lost employment, or had a child with special needs.

Overall, the weight of the evidence in this chapter suggests that mothers with greater needs receive more help, and that mothers whose circumstances change for the worse also receive more help. The exception to this overall conclusion is the finding that mothers living with a household member with a health problem were less likely to increase their use of services. Also, the results overall suggested that, all else being equal, foreign-born mothers—both Black and Hispanic—are less likely to receive help. However, it is unclear from this analysis whether foreign-born mothers are less likely to seek help, less likely to receive help when they seek it, or some combination of the two explanations.

BARRIERS TO AND FACILITATORS OF SERVICE USE

"It's help, it's a lot of help. But it's just the stuff you gotta do to get help."
~Sandra, 20-year-old, unmarried mother of one child

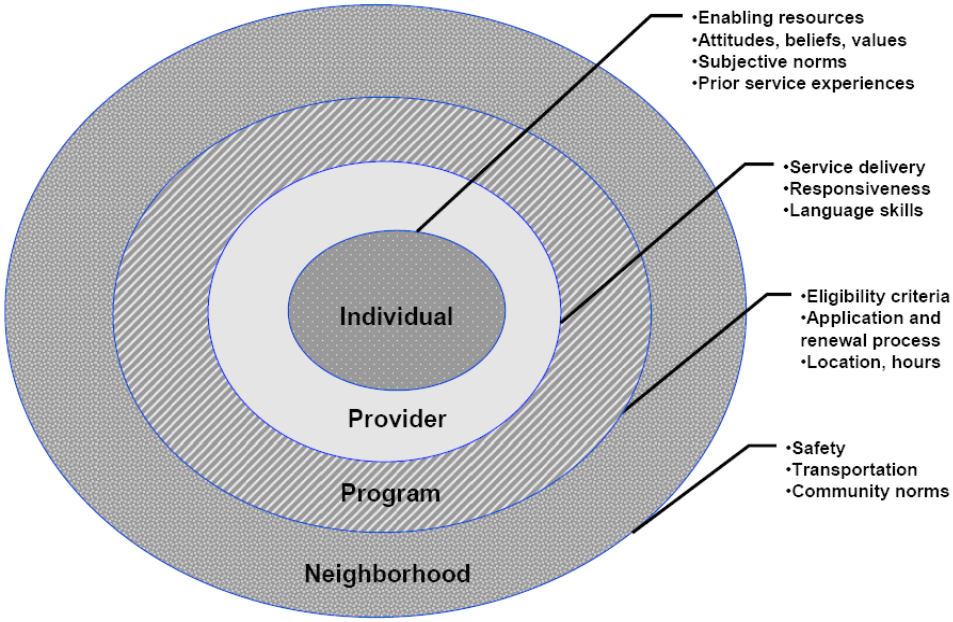
Despite efforts to increase the availability of health, educational, and social services for improving the well-being and future prospects of low-income families and youth, research indicates that the effects of these services are often modest at best. A critical challenge for voluntary prevention and early intervention programs, in particular, is engaging potential clients in services long enough to obtain the benefits that high-quality services can provide (e.g., Daro et al., 2003; Daro et al., 2004; Olds & Kitzman, 2007; Raikes, Green et al., 2006; Roggman et al., 2008). As the survey and administrative data indicate, most of the sample families had contacts with the Healthy Beginnings system of care around the birth of the focal child—in 2004 or 2005—and more than a third continued to receive services through the system during the first year after the child was born. Most of the sample families also reported receiving other services at that time, most often, health care and food assistance; only 17 percent were using five or more services. Over time, there has continued to be a small group (15%-17%) of mothers reporting use of five or more services. These appear to be mothers who have more need for services, suggesting that the service system is reaching needier families. At the same time, among mothers using fewer services, there appear to be service needs that are not being met.

In this chapter, we examine the factors that influence families' participation in services, based largely on an analysis of three waves of qualitative data covering a 12- to 15-month period starting around the focal child's first birthday. We refer to these factors as facilitators or barriers depending on their effect, that is, whether they seem to encourage or discourage service use. It should be noted that a barrier does not mean a negative experience with services nor does a facilitator mean a positive experience. As suggested by Sandra's quote above, mothers' experiences with services may be independent of the factors that facilitate or hamper their use. For example, Bayle, a 23-year-old unmarried mother of four children, while in the midst of applying for food stamps, complained that the application process was a "headache," but 6 months later, when she was receiving food stamps for herself and all of her children, she concluded, "But it is worth it when you need it."

Our analysis of the qualitative data is informed by ecocultural theory (Bronfenbrenner, 1986; Lowe & Weisner, 2004; Weisner, 1984, 1997, 2002) and the ecological frameworks developed by Daro and colleagues (Daro et al., 2003; McCurdy & Daro, 2001) for participation in family support programs and by health behavior scholars (Aday & Andersen, 1975; Andersen, 1995; Scheppers et al., 2006) for use of health services. These theoretical frameworks, as well as evaluations of specific programs, suggest that service use is influenced by many factors at different but interconnected levels—the individual, the provider, the program, and the neighborhood level (see Figure 6). At the individual level, we have identified factors such as personal enabling resources (e.g. immigration status, concrete resources, knowledge of services, personal social networks), perception of need, attitudes and beliefs about services, subjective norms (e.g. family approval or disapproval), and previous service experiences. At the provider level, the qualitative data point to characteristics of provider agencies, such as staff responsiveness, language skills, and cultural competency. At the program level, factors include eligibility requirements, program structure, availability of translation services, physical location

of services, intake procedures, and length of waiting time to apply for or receive services. And at the neighborhood level, the data suggest that factors such as neighborhood safety and community transportation systems affect families' access to and decisions to use services.[61]

Figure 6. Conceptual Model of Barriers to and Facilitators of Service Use



The analysis of *longitudinal* qualitative data indicates that the relationships among these various barriers and facilitators and service use are both complex and changeable over time. First, there are characteristics common to groups of families as well as characteristics specific to individual families: for instance, many mothers in the qualitative sample mentioned transportation as a common obstacle to service application and use. On the other hand, parents' beliefs and values about a service may be a barrier or facilitator that is unique to a mother or family. Second, what poses a barrier to one mother—for example, having to use the computer to apply for a service—may, in fact, be a facilitator for another mother. Third, these factors may be more or less applicable depending on the area of service use. As the survey results on service use indicate, mothers use different types of services to different degrees. They also are more or less likely to seek help for their concerns depending on the area of service need. The qualitative data suggest that mothers seem to be more willing to seek help in an area such as health care than in areas such as food and housing, perhaps because they have other resources for these needs or perhaps because of a belief that they should be responsible for providing food and shelter, whereas they cannot be expected to provide medical care.[62]

[61] We also recognize that the broader social, economic, and political context—for example, national and state immigration policies, the availability of affordable housing, jobs, and transportation systems, and the costs of energy and food—also impacts family circumstances, needs, and access to services.

[62] A mid-term report of a study of a community-based child abuse prevention initiative by Daro, Huang, and English (2008) indicates that people were more willing to provide assistance to neighbors than to request help for themselves.

Findings to date indicate that, over time, the levels—individual, provider, program, and neighborhood—at which barriers and facilitators occur may change. That is, a barrier or facilitator at the individual level, such as transportation, may be more prominent in the initial decision to apply for a service and the initial application process. However, program and provider factors such as the length of waiting time or provider responsiveness may be more influential with respect to service participation and retention. Alternatively, a barrier or a facilitator such as transportation may also persist at the same level over time for particular services. In most instances, the qualitative data indicate that barriers or facilitators exist at multiple levels simultaneously and interact over time. Moreover, as families' ecological and cultural worlds change, factors that inhibit or facilitate service use may also change.[63]

In the remainder of this chapter, we discuss the factors that are emerging as the most relevant barriers and facilitators in five distinct service domains—health services, food assistance, social services and community support, childcare, and housing services—based on the analysis of three waves of qualitative data. We focused on these areas for a few reasons. First, health services and food assistance were the most frequently reported services used by the study families and, therefore, figure largely in their daily lives and are likely to play a role in their children's well-being and development. In addition, these services may also affect or be affected by use of other services directly (e.g., through links with other services) or indirectly (e.g., positive or negative experiences with services in one domain may encourage or discourage service use in another domain). The next two areas, social services/community support and childcare, encompass a number of the prevention and early intervention programs and quality improvement initiatives supported by CSC; they also are important supports and facilitators of service use in other areas.

Health Services

According to the survey data, assistance with health care was the service most consistently received by mothers over time (see Table 51). Mothers' accounts in the qualitative interviews suggest that they are more inclined to overcome barriers related to use of health care services than other service areas, such as food. There appear to be two primary reasons for these differences. One reason is the value mothers associate with receipt of Medicaid and other health care assistance as opposed to receipt of food assistance, which is associated with the relative costs of health care and food. Another reason appears to be mothers' access to alternative sources of assistance in each of these areas.

In the case of food assistance, these programs grant access to an asset that mothers expect to be able to provide for their children on their own. When their financial situation is precarious and access to a food program is daunting, mothers may tap into their social and community networks to feed their children. When Tania, for example, was asked how she would manage the loss of $130 in food stamps, she responded: "I manage, very easy. Trust me if I couldn't manage I would find me a church or something where I could get food from. They are not going hungry and that is why that lady [a cousin] and Fiona's daddy is alive. We are going to be all right. I will manage."

[63] McCurdy and Daro's (2001) model also differentiates factors affecting participation and retention in services from factors affecting intentions to use and enrollment in services.

In contrast, Medicaid grants mothers access to an asset—health care—that they do not expect to be able to provide on their own. Moreover, Medicaid and other public health insurance programs cannot be easily replaced. When a child is sick or their immunization shots are due, mothers must rely on the institutions that provide the medical services they need. When describing their experience with the Medicaid program, mothers often talked about receiving immunizations for their children, physical check-ups, prescription coverage, and other medical care. In her first qualitative interview, Cristal, a 22-year-old, unmarried Hispanic mother of four preschool children, summed up the value of Medicaid as follows: "Well it covers everything. It covers the pediatrician. It covers the medications of the children, the specialists. It covers everything and I feel very good." In subsequent visits, Cristal's opinion remained unchanged. In wave 2, Cristal remarked: "I feel happy the children have medical insurance. So, if at any moment I see that the children are sick, I call the doctor, and I make the appointment." In her remark, "I feel good," it seems that Cristal believes she is behaving responsibly as a parent. Indeed, her comments reflect the goal of virtually all mothers in the sample to ensure their children's well-being. In many ways, medical coverage alleviates mothers' fear of failing to meet their children's health care needs in particular, but also, perhaps, other needs as well.

Furthermore, as far as we can tell, the cost of health care is not comparable with that of food. Indeed, without Medicaid, out-of-pocket payments for health care would likely impose a significant burden on families who are already impoverished. This was often the case in immigrant families, in which the children who were born in the United States are often the only family member covered by Medicaid, and other family members try to get by without medical care whenever possible. For Amanda, for example, the financial expense of her health care because of a previous illness only strengthened her perception of the value of Medicaid health coverage for her children: "Like I told you, I am very satisfied as long as my children have Medicaid. The rest, for us, well we pay for it and everything." Amanda reported that she is saving money and trying to avoid seeking medical care until she has saved enough to pay for it again. "It is very difficult, because as I said, it's happening that right now we don't have money now [to pay for her previous medical expenses]. And so we save every cent, every coin, and so we just go and change them all in and get dollars to pay this [medical bill].

The cost of medical care was also an issue for Carla, a 23-year-old Hispanic mother of 2-year-old Maria. For over a year, Carla has been trying, unsuccessfully, to reinstate Medicaid for Maria. Carla kept being pushed back and forth by Medicaid and Florida Kids because of confusion about which program she was eligible for. (According to Carla, when she applied for Florida Kids, she was told that Maria was eligible for Medicaid. Then, when she tried to apply for Medicaid, she was informed that Maria was not eligible for Medicaid but was eligible for Florida Kids.) In the meantime, she was bearing the cost of Maria's medical care visits and medication. Maria, on the other hand, was getting sicker more frequently since she started attending a childcare center. Paying for unforeseen medical expenses exposed Carla's family to greater financial instability. "Oh, because now that she doesn't have Medicaid, the medicines are really expensive. Just recently she got sick, and we spent a lot on her. Yeah, [my husband] doesn't earn enough. He earns very little." Carla, nonetheless, had not given up trying. In the third wave, Carla said she would try a different strategy: "I want to contact my [former] social worker, because the first time I applied, she helped me."

In short, the value of health care coverage and the health needs of children are the primary facilitators of Medicaid service use. As Flavia, a –29-year-old Mexican mother of three children, simply put it: "Sometimes my children are sick and how [can we manage] without the Medicaid?" Although mothers encountered barriers in applying for Medicaid, they were determined to surmount them given the value of this service. The fear of looming health care costs also fueled Laura's determination to confront any barrier that she might face at the provider level when applying for Medicaid. As this 32-year-old Hispanic mother of two children explained: "I go anyway [Medicaid office].... In that aspect, I don't care [about provider responsiveness]. Because if my child is sick I have to take him, whether they make a face or not, I will take him because I know I have to go."

At the same time, program and provider characteristics can facilitate access to medical coverage and make it less likely that children will experience interruptions in care. Many mothers talked about getting Medicaid during their pregnancy and then "automatically" receiving Medicaid for their newborn children during their first year. Mothers explained that during pregnancy and birth, their receipt of Medicaid was facilitated by a worker from a clinic, hospital, or social services agency. Social workers, for example, often assisted with the Medicaid application process and thereby helped to with several barriers associated with Medicaid use. For some mothers, particularly immigrant women, getting help with Medicaid enrollment initially introduced them to previously unknown services and programs.[64] In fact, as discussed in the section on care coordination services below, because of knowledge gained from previous application processes facilitated by hospital personnel, clinic staff, social services agencies (e.g. the Guatemala Mayan Center), or friends and family members, some mothers have attempted to go back to the people from whom they first received help with their Medicaid application to help them reinstate or maintain their children's health coverage. Therefore, when mothers describe their experience with Medicaid prior to recertification, they emphasize the factors that facilitate service use.

Although the perceived value and relaxed requirements for initial enrollment for low-income pregnant mothers set Medicaid apart from food stamps, these two services pose similar barriers to service use. Both Medicaid and food stamps have similar application processes and program requirements (e.g. computer application, child support enforcement). However, Medicaid also provides an easy enrollment process specifically for low-income uninsured pregnant mothers, which provides automatic health coverage for their children during their first year. As noted above, it is when Medicaid recertification is due (usually for the focal child) that its barriers begin to resemble those of the Food Stamp Program.

Thus, over time, additional barriers emerge with the recertification process. Typically, when it is time to recertify, many mothers are no longer connected with a social worker or a worker from a clinic or hospital. In order to maintain Medicaid coverage, mothers usually have

[64] Currie (2004) cites a 2000 study by Yelowitz that estimated that 40 percent of newly eligible families who took up Medicaid benefits also took up food stamps, suggesting that changing enrollment requirements for one program can affect enrollment in other programs. Families may have learned about their eligibility for food stamps when they applied for Medicaid, or they may consider it "more worthwhile to bear the application costs in the case of Medicaid and the FSP together than in the case of FSP alone" (Currie, 2004, p. 22).

to go in person to the Food Stamp and Medicaid office to recertify. As mothers talked about their experiences with these providers, they also described a variety of barriers that affected the re-application process and ongoing participation in these services. Access to transportation, monetary costs (including lost wages for taking time from work), location of services, language, illiteracy or limited literacy, lack of computer proficiency, computerized application forms, lack of provider responsiveness, and program and paperwork requirements appear to be major barriers when recertification is required. In addition, barriers featured more prominently in the narratives of immigrant mothers—who struggled with limitations posed by their language, knowledge of services, and educational background—than in those of U.S.-born mothers.

Excerpts from the narratives of two immigrant mothers, Julia and Teresa, illustrate the role of these factors in their ability to obtain Medicaid for their U.S.-born children (see Boxes 4 and 5). Their experiences also remind us that barriers to and facilitators of families' service use are unique to their ecological and cultural circumstances. For Teresa, Julia, and other low-income families with limited literacy or computer proficiency, it is challenging to access health care coverage though traditional points of entry. A seemingly simple task of completing an

Box 4. Julia
"Aun que uno le gusta o no le gusta, queda callado, es mejor.
[Whether or not one likes it, it is better to stay quiet.]"

When Julia, a 26-year-old mother of two children, had to recertify Medicaid for her younger son, Estevan, she was unable to complete the application because she is illiterate. Julia tried to enlist the help of a worker from the Medicaid office but had no success. Without assistance she was unable to recertify Medicaid for Estevan and, consequently, he lost his health coverage. Julia's experience at the Medicaid office seemed particularly undignified. During her first interview she said that if she could change anything about the Medicaid system/program it would be to hire people to work in the offices that could actually help the people who came in to the office. She said that at times when she has been in, the workers there have been very rude to her. "There are times when I asked for help, and they closed the door and said no. 'Right now I am busy. Right now I can't. Come back later. Come back tomorrow.' Moreover, she concluded that there was no point in complaining or arguing with the provider: "Whether or not one likes, it is better to stay quiet." Julia recalled that one time someone told her to call a number and then another staff member pulled the phone out of her hand while she was dialing and told her she couldn't talk to the people there. She said the workers are not helpful. She also noted that there are two offices nearby where she can apply for Medicaid, but she could not go to one of them because everything was computerized.

In the second and third wave of interviews, Julia reported that she was still trying to reinstate Estevan's Medicaid; until she could, when Estevan was sick, an over-the-counter pain reliever was the main solution. At the same time, the family's circumstances had become more challenging. Julia was facing several medical problems with her older daughter, Meli, who recently arrived from El Salvador with many physical and developmental issues, including a hearing loss. Meli was having problems at school because of her special needs. At the same time, the family's economic situation seemed more precarious, with reductions in Julia's husband's work. The family's meager income needed to be stretched to include medical care for Estevan (a U.S. citizen) and Meli. In the third wave, the mother reported that Meli was sick and medication cost $128—almost half of the family's weekly income, which Julia estimated to be between $250 and $350 a week for her family of four.

n application form may become too burdensome and, occasionally, too humiliating to endure; an alternative or a more flexible application process as well as more responsive service providers would help to reduce the number of stressors that hamper their ability to receive services.

Box 5. Teresa
"Está bien complicado …uno calienta una cabeza grantoda [aí]
[It is very complicated …like your head will explode]."

When Teresa, a 27-year-old married mother, gave birth to Adriana, her second child, a worker at the hospital helped her file the Medicaid application for her daughter. In her first interview, Teresa recalled her delight that Adriana was eligible for Medicaid for 1 year: "It [Medicaid] covers the medicine, the doctor's appointments." One year later, when recertification was due, Teresa filled in the Medicaid application form on paper in Spanish and sent it by mail. She seemed to find the process relatively simple: "One brought it [the application form] home and filled it out.… Yeah, it is instantaneous."

However, Teresa mistakenly thought that Adriana was covered for another year. When we interviewed Teresa in the second wave, she explained that she misunderstood the Medicaid expiration schedule. She realized that Adriana had lost her health coverage when she was at the clinic seeking medical care for her when she was sick. Teresa immediately went from the clinic to the Medicaid office to find out what had happened and learned she had to reapply for Medicaid. However, to her dismay, there was no paper application anymore. The application had to be done through a computer. "Now the applications [paper applications] do not exist. No, it is just like that." She acknowledged that "it is easy for the people that know how to use a computer, because that way, one doesn't have to deal with a lot of papers." However, she explained, "For me, it is very complicated; if one doesn't know how to use [the computer], it is difficult because, maybe they are going to do it well, or maybe there is one thing they didn't put right and it all erases and they have to start all over from the beginning."

Teresa's frustration did not stop with the computer application process. "One get frustrates (cabeza grandota) there… and with ton of people there. Where one doesn't have any space, and the computers are busy. And the kids are there crying,…" Teresa confessed that she does not like to go to the office unless it is really necessary, "sometimes [the staff] are real jerks." Fortunately she could enlist the help of someone at the office to assist her with the computer application. "About 20 days later, I called and they told me she had Medicaid," she rejoiced. In wave 3, Teresa recounted yet another experience with Medicaid. When she needed to recertify Adriana's Medicaid again, she tried to use the computer but could not finish the application because the computer system went down. This unexpected happenstance worked to her advantage. With the computer system down, the staff provided Teresa with a phone number that would allow her to receive a paper version of the Medicaid application. In the end, the Medicaid paper application facilitated the health coverage application process in two ways. First, it helped Teresa bypass the computer application. For Teresa, trying to use the computer was especially challenging when she had to simultaneously attend to her daughter. Second, it cost Teresa less money. In telling of her experience, she laughed as she concluded, "[To go to the Medicaid office] by taxi, it costs like $25 or $30. So, it is cheaper to do it by mail."

Non-immigrant mothers also reported difficulties with the Medicaid application and recertification process, which required applicants to supply a number of different documents and, if not married, to have filed for child support. Sandra, a 20-year-old African American single mother of a toddler, DeAndre, also encountered many barriers when it was time to recertify DeAndre's Medicaid. First, Sandra was unaware that she needed to renew Medicaid for him: "I was supposed to enroll again but I never knew that." At the time, she recalled, she was frazzled

and confused: "It was so hard for me to get Medicaid for my baby again. I was even crying. I was like, what am I supposed to do? I don't know what to do." Sandra realized that in order to reinstate her son's Medicaid coverage, she would need to compile the necessary documentation and pay a visit to the child support office. "They'll write it down you need to bring your ID, social security, birth certificate…but [if] you didn't ever go down to the child support office, you will not get help until you go." For Sandra, transportation was also confusing, "I only take one bus there and that is it and I take the same bus back. I always keep up with the time so for some reason I know what time every bus comes.… That is a lot to remember." Fortunately Sandra could count on the help of a worker from Humana who seemed invested in helping Sandra: "I called [Humana/Medicaid]. She came to my house one day and was like, 'I really want to help you get Medicaid.' She helped me, and one day I received a phone call from her and she was like, 'Congratulations, the Medicaid finally went through.'"

Access to health care was a recurring topic for most mothers in the qualitative sample but especially among uninsured mothers. For these mothers and their uninsured children, community health clinics and hospital emergency rooms are the main sources of health care. Mothers reported using community health clinics for a variety of health care needs, including treatment of illness, minor emergencies, family planning services, children's immunizations, dental care, children's school physicals, and parenting information. In the qualitative sample, nearly all of the mothers who talked about their experience with community health clinics were immigrants. This is not surprising given that in the third year, only 15 percent of the U.S.-born mothers were without health care coverage compared with 71 percent of the foreign-born mothers. Immigrant mothers also were more likely to use public health clinics for health care than native-born mothers (61% vs. 13%).

By the third wave of the qualitative data, however, mothers talked less and less frequently about the use of community health clinics. This appears to reflect, in part, a general decline in use of services for their own health care. As previously noted, prenatal care comes to an end after childbirth, and mothers lose the Medicaid health coverage they received while pregnant two months after the birth of their child. As a result, use of health care services after the birth of the child becomes inconsistent. As their children get older, mothers also may perceive less need for regular health care for themselves, although most of our sample reported keeping up with their children's health care.

In addition, mothers' description of their experiences with community health clinics over time revealed many other barriers at the individual, provider, program, and neighborhood level. Transportation problems, difficulties communicating in English, transaction costs, health care cost, long waits, and lack of provider responsiveness were some of the major barriers discouraging their use of community health clinics. In addition, community health clinics seemed to differ in terms of their fees, the scope of their services, and program rules. For example, some mothers spoke about clinics in which a donation was the form of payment for health care received, and others spoke about having to pay a relatively large sum for health care received. Moreover, though some mothers described community clinics that offer a wide range of primary and specialty health care services, others spoke about community health clinics that only provide prenatal care and family planning services.

For Gabriela, a 27-year-old Hispanic mother of a 2-year-old girl, a visit to the health clinic meant dealing with several issues—transportation problems, lack of provider responsiveness, and out-of-pocket health care expenses. When a trip to the health clinic is needed, Gabriela relies primarily on public transportation. However, going to the clinic by bus is not very easy. "It [takes] like 45 minutes to get there.… And with the sun, sometimes it would rain, there was nowhere to cover yourself. I would cry. I would call my husband if it by chance he were around to pick me up. But if not, I would have to tolerate the sun and rain," Gabriela reported. Furthermore, once at the clinic, Gabriela was also uncomfortable with the way she was treated. She perceived the clinic frontline staff as rude and angry. Whenever possible, Gabriela avoids seeking health care at the clinic. "I want to avoid [going to the clinic] right now. I am not in the mood to have a bad time," she said when explaining why she was not seeking medical care for a recurring ear problem. She went on to say she was "traumatized" by her previous experience. Finally, having to pay for health care is also problematic. "Well, when I use the clinic, it is not that I don't pay…I get into debt."

Cost of health care was indeed a concern voiced by many mothers. For example, Elvia recalled that when she was sick she sought help from a private physician because "even if you go to the clinic where they help you, they always say it is this amount for prescription, it is this amount for the doctor, and there, the prices are always very high." Leticia, on the other hand, is trying to find a way to get health coverage for her 4-year-old son. She had to pay $140 for his physical at the health clinic, a substantial sum for a family with six dependent children that makes between $150 and $350 per week.

For other immigrant mothers, cost was less a barrier than other factors, such as language discrimination and insensitive providers. For example, Cristal believed that the waiting time at the clinic was related to the lack of Spanish-speaking personnel and language discrimination. "The person who speaks English goes in first and you stay until the last one waiting until someone comes to translate for you." Similarly, Silvia's lack of English skills became an issue when interacting with the health clinic staff: "Well, sometimes if one does not speak English, they get mad or something like that.… One time someone said, "Why don't you speak English?… You have to dedicate yourself to learning English."

Counterbalancing these barriers are the factors that make it easy for mothers to use community health clinics. The most notable facilitator was the instrumental support mothers received from friends, families, and social workers. Mothers' informal and formal social networks facilitated their use of the community health clinic by helping with transportation, childcare, language, information, and paperwork. For example, a worker from the Guatemalan Maya Center assisted Silvia, a single mother with one child, with appointments and transportation. For Silvia, it was helpful to have a bilingual worker acting as a liaison between her and the health clinic because, as she reported, at the clinic "sometimes they don't speak Spanish and sometimes yes." Laura, a mother of two children, reported that a worker from Healthy Mothers/Healthy Babies helped with transportation: "Sometimes she would get me a bus pass to go to the clinic. And when I had to make appointments in the clinic I could not make, sometimes she took me."

Food Assistance Programs

Although food assistance was the second most frequently reported area of service use, the survey data showed a decline in the use of food supplement programs—WIC (Women, Infants, and Children) and food stamps—from year 2 to year 3. This same decline was evident in the analysis of qualitative data among both immigrant and native mothers. The qualitative data also suggested a greater decline in use among working mothers than non-working mothers, results that are consistent with the regression analysis indicating that maternal employment was predictive of a decline in overall service use (see Table 55). Moreover, the qualitative data also indicated the same variability by nativity found in the quantitative analysis of the survey data. That is, continuing trends from the first and second years of the study, immigrant mothers were much more likely to use WIC than food stamps (71% vs. 24%) and more likely to use WIC than native-born mothers (71% vs. 46%) in year 3.[65] Native-born mothers were about as likely to use food stamps (47%) as WIC (46%).

WIC

Mothers' accounts of their experience with the WIC program revealed barriers to service use at multiple levels and variations in these factors at different points in time. At the individual level, barriers included missed appointments; attitude perception and beliefs (e.g., cost-benefit perception); knowledge of program requirements and guidelines; time constraints and costs; lack of childcare and/or transportation; language and literacy proficiency; and expense. Additional barriers at the provider and program level included provider responsiveness, capacity, and resources (e.g., waiting time, crowded spaces, and inconvenient office hours), and program structure and requirements.[66]

Missing WIC appointments was a salient theme across the first three waves of qualitative data, with several mothers reporting missing appointments at some point during this 12- to 15-month period.[67] Mothers who missed appointments often cited individual factors such as lack of knowledge of program guidelines and requirements, confusion about appointment dates, health problems, transportation issues, and work schedules that were not compatible with agency office hours. Missed appointments resulted in non-use of services for a period of time, which varied depending on how mothers followed up on a missed appointment. Thus, we found that mothers

[65] Immigrant adults are ineligible for food stamps until they have lived in the United States for 5 years, unless they are receiving disability benefits, were admitted for humanitarian reasons, or are a member of a selected immigrant group (e.g., Haitian or Cuban); however, their immigrant children, regardless of entry date, are eligible, and eligible household members can get food stamps even if other members of the household are not eligible. Immigrants are eligible for WIC regardless of whether they are documented or not (www.fns.usda.gov; www.nccp.com).

[66] For example, the brand of milk formula allowed by the WIC program may differ from that given at the hospital, and some babies reject milk from another brand.

[67] According to a staff person at the PBC Health Department (personal communication, August 2008), mothers are required to take their children to the WIC office each time they need to recertify the WIC benefits, that is, every 6 months, but also when the nutritionist wants to see the child. Thus, the number of visits a mother and child make to the WIC office will vary according to the nutritionist's perspective on the child's health needs; if the nutritionist believes that the child needs to be seen more often, then the mother will have to take the child to the WIC appointments more often. In the case of Teresa, described in this section, the nutritionist may have been concerned about her daughter's weight and thus have scheduled additional appointments to see her that were neither related to recertification nor related to picking up WIC checks.

who missed appointments followed different service use trajectories over time. For example, some mothers postponed using the WIC program for an indeterminate time. Others rescheduled or tried to reschedule another appointment. During this period of rescheduling WIC appointments, some mothers were temporarily withdrawn from the program and others quit the program altogether.

Teresa, a 28-year-old Hispanic mother of a 2-year-old girl, Adriana, and an 11-year-old boy, Daniel, missed a required appointment at the WIC office when she forgot that she was supposed to take Adriana, who was 10 months old at the time, with her. Teresa tried to reschedule her appointment over the phone and was informed she would receive a call back informing her of a new date. She never received a call back and decided not to go back to the WIC office: "I called to renew her appointment and they never gave it to me, so I never went back." Six months later, Teresa reported that she was receiving food stamps and would probably not be eligible for the WIC program. "I thought about going, but I say, since they give me food stamps, they will probably deny me." In our third visit, another 6 months later, Teresa was asked again about her intention to apply for the WIC program. Teresa reiterated her belief that receipt of WIC services would jeopardize receipt of food stamps. "No, I haven't gone back there. With what they give from food stamps, well it helps us with something. And I don't know, I haven't gone because maybe it will affect getting food stamps if I get WIC." Teresa, who is currently living in another neighborhood, also realized that the cost of transportation would not justify a trip to the WIC office. She concluded, "No, because since it is so far as well. Imagine, I have to pay a taxi, $30 from here to Lantana. It's better that I just pay for the milk."

Teresa's accounts of her experience with the WIC program highlight how a missed appointment can be only the first of multiple barriers to service use over time. As Teresa's accounts unfolded, she revealed other barriers, including transportation, provider responsiveness, affordability, and individual attitude, perceptions, and beliefs. Her experience is consistent with the findings of a recent study of attrition in Early Head Start home visiting programs, which suggest that "dropping out" of the program was predicted by both family characteristics and the content and duration of visits (Roggman et al., 2008). Teresa's accounts also highlight the shifting and mufti-faceted nature of the factors that hamper service use over time.

For some mothers, previous difficulty accessing the WIC program was another key factor discouraging service use. Sandra, the 20-year-old African American single mother described earlier, stopped using WIC after her 2-year-old son, DeAndre, turned 1 year old. Sandra did not feel comfortable taking DeAndre with her for every WIC appointment. For her, going to the WIC office with DeAndre meant exposing him to the blazing heat while waiting for the two buses that would take her to the office. It also was a long ride for her and DeAndre because, she complained, "[The bus] goes everywhere." In addition, Sandra felt it was excessive to have to take DeAndre every month to a physical before their appointment. "And when I went every month, they give you this slip that you have to take to your child's doctor and the baby basically has to get a physical, a hearing, eye [check]. And the doctor fills out the [form] and you have to take it back to the office." In the following two visits, Sandra reiterated her discontent with managing appointments at both the WIC office and DeAndre's pediatrician. Sandra also elaborated on program and provider factors hampering the use of the WIC program when explaining how WIC works:

> Like I would usually get it for 3 months, so I couldn't even spend the other 2 months until next month, and the month after that came and it was on that date. After all that is over with, then you go back in, and then you make an appointment again. All over again. [She laughs.] And it's help, it's a lot of help. But it's jes the stuff you gotta do to git help.

Sandra also was ambivalent, at best, about the attitudes and behavior of the staff at the WIC office. While reflecting back on her experiences with the WIC personnel, she speculated that a mother's experience with and willingness to participate in the WIC program depends considerably on the provider assigned to her:

> Some of them know how to talk to you, and then some of them don't. Like, you can have a teen mother [who] is gettin' WIC for the first time and don't know how it works. And then when she gets there, they'll get mad and be like, "Well, ma'am, you need to make an appointment. I don't understand how y'all mothers come in here and don't know that y'all need to make an appointment." And then it hurts, you know, sometime to know that, "Okay, I didn't know." It's crazy sometimes. You got some people that have an attitude with you, but sometime you got some people that take it because they need the help. And I feel that you're helping us, you gotta know how to talk to us sometimes. You got some people that are very sensitive about what you say to them and then don't wanna come back, and they think that they can't get help because of the way people is talkin' to them. I mean, I care less if somebody talk to me, you know, mean or anything because I know I'm tryin' my best to do what I gotta do to get help.

Many mothers in our sample concurred with Sandra's view on the connection between provider characteristics and experience. Debra, a 21-year-old single parent of a 2-year-old, reported that the WIC staff are usually "helpful and nice," except on days when the office "is very packed, and it's only one or two nutritionists there." Amanda, a 28-year-old Guatemalan mother of four children under the age of 6 years, had been using WIC off and on during the year in which our interviews occurred. When asked about her experience at the WIC office, she described it as "sometimes good, sometimes it depends on the person that you end up with. Sometimes one doesn't understand and, then, because one doesn't speak English and they ask why you don't learn English, say that they don't speak Spanish, and we need to learn English."

Yet, as Sandra noted, despite these difficulties, some mothers continue to participate in the WIC program because their need to provide for their families is more important than the barriers they encounter. For example, Ivana not only confronts her language and literacy limitations but also takes an extra step to get the help she needs every time she is required to complete the paperwork at the WIC office. Ivana's struggle with language and literacy are captured consistently across her three interviews. When asked if a worker at the WIC office assisted her with her application, she responded:

> No, just someone who goes there for their appointment. I ask them if they could fill out my papers, and they fill them out. And [then] I take them to where I have to hand them in and that's it. One time I went, and since I did not see anyone who looked like they knew some Spanish and a little English, so I went when they

> called me and the woman who worked there scolded me and said, "why didn't you fill out the papers?" I told her, "I don't know how to read or write. I don't know." "Ask someone who is there. Ask someone who is there and who knows how to read and write as a favor." I went back out and I saw a lady and I asked her if she talked Spanish. "Yes. I know a little." And so I asked her if she would do me the favor to fill out the papers and she filled them out for me. And I went to hand them in and only like that they were able to give me my WIC checks.

Ivana's experience is not unlike that of Sandra, Amanda, and Teresa, in that access to service may vary according to the provider assigned to them at the WIC office. It is interesting, though, that Ivana believes her chances of getting her application filled out increase when the WIC office is crowded. She says, "Sometimes there is not a lot of people I can ask. Sometimes it is really crowded and they fill out the papers for you." However, these barriers do not stop Ivana from seeking help; she placed great value on the help she receives with the WIC coupons and is grateful. Ivana concludes: "Everything is good with WIC because they give milk, juice, and like that to all children. Because sometimes in the store it is expensive. And WIC give us a check and we only have to go to look for the things in the office and that's it."

Ivana's narrative also points out that most service experiences typically include both barriers and facilitators. Moreover, the relationship between barriers to and facilitators of service use in a particular area may change over time. Ivana's account illustrates that the factors that dominated mothers' decisions to enroll in and participate in the WIC program were their perceptions of need and the value of the help received from the program. Indeed, mothers' perception of the tangible benefits offered by the WIC program reduced the significance of program-related barriers, such as frequent visits to the doctor and program office to maintain benefits or long waits for service at the program office. Most mothers, whether immigrant or native-born, who talked about their experiences with the WIC program voiced similar comments about the benefits of having WIC, comments that were reiterated over time in follow-up interviews. A sampling of their comments include the following:

> We save money with what they give to us and sometimes is a lot. (Gabriela, a 27-year-old mother of a toddler)
>
> It is a great help that they give. (Cristal, a 23-year-old mother of four children under the age of 5)
>
> WIC helps a lot, they help with his milk. (Lariza, a 28-year-old mother of three children under the age of 3)
>
> It is a huge help. (Miriam, a 26-year-old mother of 2-year-old twins)
>
> It is good because milk is expensive. (Linda, a 26-year-old single mother of a newborn and a toddler)
>
> It's a long wait [at the office] sometimes, but I like it a lot. It is helpful; it saves me a lot of money. (Tracy, a 20-year-old mother of two young children)

In addition to food assistance, some mothers reported other benefits of the WIC program. Tatiana, a 29-year-old Hispanic mother of a 2-year-old girl, has used WIC in the past year and, like most of the mothers using WIC, found the benefits very helpful. Although she missed one of her appointments because she had a dentist appointment scheduled the same day, unlike Teresa, she said it was easy to reschedule: "Normally [rescheduling an appointment] is easy.

One just goes and they give it to you the same day that you go." Tatiana's access to and use of the WIC program was facilitated by several factors including language, transportation, perceived value of the information received from the nutritionists, referral to free dental care for her daughter, and length of wait. Tatiana does not drive, but sometimes can count on a neighborhood friend or her cousin with whom she lives to drive her to the WIC office. When she cannot find a ride, she usually takes a taxi, despite the expense.

Importantly, Tatiana also appreciated and seemed engaged with the educational resources the WIC program provides, that is, the information she receives about her daughter's nutritional needs and dental care. As she explained, "Sometimes they give us a talk. The last time I went, they gave us a talk about teeth for her. And since she doesn't have Medicaid, I got the appointment for the dentist. We just got it. I have to take her to the dentist." She also found it helpful as a first-time mother to get parenting information in her language, Spanish, provided at the WIC office: "Since it is the first child I have, it has been a little difficult. Because there they give us all the brochures and one reads them. And they are in Spanish, too. Everything is in Spanish."

Over time, across the first three waves of qualitative data, mothers who used the WIC program continued to talkabout both the barriers to and the facilitators of participation in the program. Barriers to WIC services appeared to cluster around the individual and provider levels and were often tied to personal enabling resources and provider characteristics, respectively. Barriers at the program and neighborhood levels were also reported but to a lesser extent. In Sandra's case, lack of neighborhood resources (e.g., limited transportation), provider behavior (e.g., lack of responsiveness), program requirements (e.g., need for continuous visits to the WIC office and medical appointments), and beliefs and attitudes toward going to the WIC office (e.g., reluctance to subject her son to the heat) all hampered service use at different points in time. Factors facilitating use of the WIC program tended to group around the individual level and were associated, first, with attitudes, perceptions, beliefs, and values (e.g. need) and, second, with personal enabling factors (e.g., access to transportation). Overall, mothers who talked about the factors that facilitated service use over time often cited transportation, bilingual staff, location, informal and formal networks that provided childcare and transportation, program requirements (e.g., documentation), provider characteristics, and information received from program staff (e.g., nutritionist).

Food Stamps

Whereas mothers were more likely to talk about barriers to service use at the individual and provider level when discussing their experiences with WIC, they were more likely to talk about program barriers when reporting on experiences with the Food Stamp Program. At the same time, we again observed differences within the qualitative sample by nativity. Immigrant mothers were more constrained by individual factors than their non-immigrant counterparts—especially when first applying for food stamps—as they continued to cite limited computer proficiency and language skills, transportation difficulties, insufficient or inaccurate information about the program and its requirements, and previous negative interactions with service providers. In contrast, although native-born mothers were also negatively affected by impersonal and unhelpful staff, they were mainly constrained by some of the requirements of the Food

Stamp Program, particularly, the necessity to file for child support if unmarried; the latter is a partial reflection of the fact that native-born mothers in the sample were less likely to be married than immigrant mothers.

Typically, when faced with the computer application process and unresponsive staff, immigrant mothers were able to apply only with the help of another person. For example, Julia, whose difficulty with the Medicaid application process was described in Box 4, said she was unable to apply for food stamps because she did not know how to use a computer. "I tried to apply," she explained, "but there in the office you have to apply by computer and since I don't know how to use one, I haven't applied for them." When asked whether there was someone at the office who could help her, she tersely stated, "They don't help you." It was only in the third interview that Julia reported receiving food stamps; through a free health clinic, Julia was able to enlist the help of a social worker who helped her fill out the online application.

Lariza, a 28-year-old Guatemalan mother of three young children whose husband earns no more than $70 a day when work is available, told a similar story. "Well, [the food stamps application] is a little difficult [because] it is by computer and I don't know anything about computers." Lariza also echoed Julia's view regarding the responsiveness of the staff at the Food Stamp office: "No, they barely help people." However, Lariza was able to recruit another person applying for food stamps to help her with the computer. By the time of her next interview, she reported receiving food stamps, a crucial asset to her family. "Thank God they are helping me," she rejoiced. "They are giving me these food stamps. That is what is helping me."

Silvia, a 19-year-old Guatemalan single mother of a 2-year-old girl, also did not know how to use a computer but was helped by a bilingual staff person at the Food Stamp office. Six months later, though, Silvia told us she was no longer using the Food Stamp Program. For Silvia, transportation and language made it difficult for her to recertify food stamps. A year later, Silvia still did not feel inclined to apply for food stamps. She explained that she would only apply for food stamps if she were not working. This decision was reinforced by Silvia's inaccurate perception of the eligibility criteria for food stamps: "Because they say when you are going to apply for food stamps, they only give them to those who are not working."

Unlike most of the immigrant mothers using food stamps, the computer application process seemed to be a boon for their native-born counterparts. Debra reported:

> Food stamps, they made it easy because now it's on computer. You just walk in there, get on whatever computer you see, and put down the information. Once you do that, you press "finish" and that'll get sent over to the people. You don't wait more than 10 minutes. Once they receive your paper, they call you up there and go through your package and make sure everything is correct. Then they'll tell you, "You'll get a response from us within a couple of days or a week."

Paradoxically, a side benefit to the computer application process might be a reduction in the amount of interaction with unresponsive staff. Latoya, a 30-year-old single African American mother of five children, noted: "The staff are good because I be on the computer. I don't see them. I just be on the computer to recertify and then they send me a letter in the mail."

On the other hand, native-born mothers were more likely to report program-level barriers to food stamp use. Most frequently, they complained about eligibility criteria, administrative paperwork, and the necessity of filing for child support in order to receive food stamps. Nearly all of the mothers in the qualitative sample who complained about filing for child support were U.S.-born mothers, which is not surprising because, as noted above, immigrant mothers were both more likely to be married and less likely to be using food stamps than were native-born mothers. The requirement to establish their child's paternity and the whereabouts of the child's father seemed to only add more layers of obstacles to food stamp use because it forced mothers to choose between reporting their partners and receiving food assistance. As a result, some mothers opted out of food stamps when faced with the decision to file for child support against their partners when they were consistently providing help for them and for their children. "If he wasn't doing what he was doing then I would but he is taking care of him. So I give him that credit," says Denise, a 20-year-old African American mother of two toddlers. In all three of her qualitative interviews, Denise expressed the same sentiment; she had no intention of filing for child support.

Even if mothers decided to file for child support, Bayle's experience shows that they usually faced lengthy waits for the child support office to process their paperwork (see Box 6).

Box 6. Bayle
"If you need the help, you got to do whatever it takes."

Bayle, a 23-year-old African American single mother of three children ages 2, 3, and 4 years, addressed several of these food stamp barriers when she described her experience with food stamps and, inevitably, the child support office over the year. According to Bayle, in order to receive food stamps, she had to file for child support first: "The food stamps it was kind of frustrating because it kept sending me to go to child support." Because Bayle does not have a car, she tries to reconcile with the idea of having to catch three buses to get there. In fact, Bayle's use of food stamps was temporarily halted when she missed an appointment due to a transportation problem. Bayle said she is planning a visit to the child support office soon.

Six months later when Bayle was 3 months pregnant with her fourth child, she admitted, "It's really confusing right now." Despite the confusing times, Bayle continued to move ahead with her food stamps application and child support paperwork. As she tolerantly put it, "I have been dealing with them ever since 2003." In fact, Bayle was recently at the child support office and had given all the required information related to the father of her two older children and the father of her two younger children. She also filled out an application for food stamps (and Medicaid). Although she found the application process relatively easy, she complains about the "meddling in your business." She says: "They want to know what you made, how you get the money or if people help you. They want to know who helped you, why they helped you, how they helped. Like a little deep." Bayle described the whole process as a "headache." When asked to reflect on the whole experience, she concluded, "I don't like the whole process, but if you need the help you got to do whatever it takes I guess." In our third visit, another six months later, Bayle told us she was receiving food stamps for herself and all four children. Not surprisingly, Bayle reiterated her discontent with the Food Stamp Program requirements but unpredictably concluded, "But it is worth it when you need it."

Tania is an example of a mother who initially went through the process of filing for child support so that she could obtain food stamps. However, she later decided to give up this assistance both because of problems with the application process and the child support requirement. A divorced Jamaican mother of two girls, 11 years and 16 months, she explained, "I didn't reapply because I done get so sick and tired of them. So, I just leave it alone," after describing a series of problems that started when she received a letter communicating that Fiona, the younger daughter and a U.S. citizen, was denied food stamps. "You go in there, they ask you the question. I mean, they're asking the same thing and you be giving them the same answer, and then they're acting like you be lying or something, you know," Tania said, in relating her follow-up visit to the Food Stamp office to obtain information about the letter denying her daughter's services. She was unable to figure out what went wrong with the food stamps application: "I don't know what I did wrong on the application."

In our second interview with Tania, she still reported not receiving food stamps. She also added this time that the child support requirement for food stamps receipt kept her from reapplying. She explained: "[Fiona's father] helps me with her so I don't see the reason…. And if he helps me, why would I try to take something that will give the man child support. I won't do that so I guess they talked about separating the household and all that mess, so I just leave it alone again."

Thus, although mothers were more likely to express frustration with the Food Stamp Program than not, the qualitative data suggest that those using this benefit were motivated by their needs for assistance. An additional facilitator, as discussed earlier, was having someone (e.g. a family member, a friend, notary public, another applicant, or a social worker) help them fill out the application forms or, in some cases, provide rides to the program office. We also observed in the qualitative data that some mothers seemed more disposed to put up with the program requirements and application process than others. One reason might be a positive relationship with the father of their child that made them less reluctant to file for child support. Another might be their luck in being assigned to a responsive staff person. But another enabler seemed to be the personal characteristics of some mothers, including their attitudes about asking for help, their knowledge of program rules, and their ability to advocate for themselves with office staff. Brenda, described in Box 7, appears to be an example of a mother whose positive experience with the Food Stamp Program was shaped by her attitude and determination.

Overall, mothers reported more barriers than facilitators when describing their experience with food stamps. Yet, the perceived value of this assistance was for mothers like Brenda and Bayle an important facilitator of service use. For other mothers, such as Tania and Denise, satisfaction with the financial support provided by their partners and the complex application process were factors that outweighed the value of food stamps. At the same time, we observed that the barriers to and facilitators of food stamp use varied for different mothers, as a function of language, level of education, and social support, among many factors. What posed a barrier to some mothers was, in fact, viewed as a facilitator by another mother, as evident in the differing responses of immigrant and native-born mothers to having to apply online for services. Unless they had someone to help them, immigrant mothers struggled with online applications that were easy for most native-born mothers, whereas native-born mothers experienced other barriers to service use. Interestingly, the online application process might also have reduced office wait

times and the number of potential conflicts between mothers and office staff; this might be one reason that over time, barriers to food stamp use at the provider level were reported less often. On the other hand, it also might have kept staff from developing the necessary skills to respond professionally and sensitively to immigrants and other prospective clients having difficulties with their applications.

Box 7. Brenda
"I never had a problem with 'em. I go out there and say something, they do it."

Brenda, a 24-year-old African American mother of three children ages 1, 3, and 5 years, talked favorably about the Food Stamp Program in her first qualitative interview. She not only was grateful for the food assistance, but she also found program staff responsive: "When I go out there and I ask for somethin', they do it right away," she reported in her first qualitative interview. When asked to elaborate, she said: "Like, one day they had cut my food stamps down, and I went out and I ask what was the reason. They were saying because I was getting welfare. I had showed on paper I haven't got welfare in five years. My oldest boy 5 now, been over 5 years." With the proper documentation, her previous, higher level of support was reinstated: "So, they put it back up, they gave me the thing 'cause they had proof they had me with welfare, and all that." Thus, in Brenda's opinion: "They do their job out there. I never had a problem with 'em. I go out there and say something, they do it."

In her next interview, 6 months later, Brenda continued to praise the program and its application process, which she seemed to find quick and straightforward: "It is all right. You just go there, and you sit at a computer and do your application on a computer and then you press print. It goes out to them and you be finished, and that is it as long as you be there before the 15th [of the month]." She stressed the importance of knowing the application deadlines for maintaining her service: "You have to do that every 6 months, but you got to be there before the 15th. If you come after the 15th, the food stamps don't come that month."

In other comments, Brenda repeatedly displayed her knowledge of the recertification process and the importance of knowing the date for recertification: "You got to be in their office to be recertified before the 15th of that month; [if you aren't] then you have to wait until way next month to be recertified. You would be recertified, but you are going to have to wait until next month to get your food stamps." She recalled that once she failed to renew her eligibility by the 15th because she was sent to jail for a domestic dispute. At that time Brenda felt powerless: "The food stamp office is right next door to there [jail]," she complained when explaining how close and how far she was from the Food Stamp office. That was the only time Brenda voiced any criticism regarding food stamps. "I showed them the papers [police report] but the people don't care, you got to be there. You got to be there with them. They don't care."

Brenda also conveyed the importance of not interrupting her benefits for the sake of her family: "My children will be wanting to eat. I got to be there, they be wanting to eat. My boy he loves his fruit, he loves his vegetables. I got to get it. He is a big boy, he loves it. He don't take no stuff [i.e., junk food]; he loves his fruits and vegetables. I got to get it. If I don't he will have a fit, he will have a fit. In her third interview, Brenda repeated her praise and gratitude for the program, nourished by the fact that she had recently received an increase in her food stamp allotment because she was pregnant again.

Care Coordination, Social Services, and Community Support

As with the larger survey sample, a large majority (84%) of the families in the qualitative study received services from the Healthy Mothers/Healthy Babies Coalition and the Healthy Start/Healthy Families program, which were the primary entry points to the Healthy Beginnings system of care in 2004 and 2005 when the study began. Mothers in the qualitative sample received a median of 6 contact days of care coordination services before and after the birth of the focal child. In addition, twenty-three families received more intensive care coordination and other services from other agencies in the Healthy Beginnings system in 2004 and 2005.[68] Participating agencies recorded in data for the sample included Esereh Youth & Families, Haitian American Community Council, Guatemala Mayan Center, NOAH, HUGS for Kids, American Lung Association, Center for Child Development, Sickle Cell Foundation, and Families First WHIN. Families receiving more intensive care coordination had, on average, thirty visits from provider agencies; most of these services occurred during the first year after their child's birth. Overall, the qualitative sample had more contact with care coordination services (median of 6 vs. 5 days) and, if they received intensive care coordination, more days of contact (median of 24 vs. 22 days) than the larger survey sample.

According to administrative data for 2005, a majority of the services in the Healthy Beginnings system were received by the study families in the first year after their child's birth. Correspondingly, mothers in the qualitative study were more likely to report contacts with these providers in the first wave of interviews than in later waves. As described in the sections on health care and food assistance, several mothers talked about their experiences receiving help from agencies in the Healthy Beginnings system in obtaining Medicaid, food assistance, and childcare subsidies. However, unless they were expecting or had recently given birth, they tended to use these providers sporadically beyond the first year; thus, over time, there also was a decline in the references to care coordination and other social services in mothers' narratives. The programs' focus on care coordination and services during the prenatal period and the first year or two after birth was the major reason for decreasing rates of involvement in care coordination services cited by mothers (although a couple of mothers also complained about caseworker responsiveness). As Laura, a 32-year-old married Mexican mother of two children, explained, "Since now my son is over a year old, they took me out of that program."

In addition, mothers reported receiving help from other community agencies, including faith-based organizations, with food and clothing; provision of toys, bus passes, diapers, and car seats; paying for electric bills; and providing emotional support and parenting information. Specific agencies mentioned by mothers included Adopt A Family Building Blocks, Kids in Distress, the Home Instruction for Parents of Preschool Youngsters (HIPPY) program, the YMCA, the Salvation Army, and the neighborhood library. Some mothers also talked about the

[68] It should be recalled that the qualitative sample was drawn from mothers who gave birth in 2005, and the study began in the spring of 2006, around the time of the focal children's first birthday. This analysis is based on the first three waves of qualitative data, which were collected in spring 2006, fall 2006, and spring 2007. Because of changes in the Healthy Beginnings database in late 2007, at the time of this report, we only have access to service records for 2004 and 2005. It is likely that some mothers in the qualitative sample also received services in 2006 and, if they gave birth to a child subsequent to the focal child, in 2007 from providers in the Healthy Beginnings system, but we do not yet have data for these years.

generosity of their older children's teachers in helping their families with donations of clothing and food, as well as referrals to other agencies.

Mothers used these programs at specific points, sometimes because of a need resulting from a sudden change in their circumstances and sometimes because of limitations set by the agency. For example, Gloria described her experience with Adopt A Family, recalling: "There was a time I wasn't getting any food stamps, but what I did was I called them [Adopt A Family]. She let me pick whatever I need.... I mean toys, clothes, socks, panties, underwear, whatever I needed.… She gave me a bunch of food. It was like 'Wow, thank you so much.'" The program, however, came with a rule, she explained: "It is like every 3 months. That is the catch, you can't come back; you got to do it every 3 months."

Faith-based organizations seemed to play a distinct role in these families' communities. Mothers spoke about these organizations not only in terms of sources of emotional support, parenting information, and concrete resources, but also as a source of health care. For example, two immigrant mothers referred to a health care clinic connected to a church where they received free dental and health care upon proof of income. By contrast, there were mothers who were not aware of any faith-based or community organizations, did not perceive a need for assistance from these organizations, and were hesitant to seek help due to the possibility of service denial.

Most mothers in the qualitative study described positive experiences with care coordination and social services, in partbecause of the perceived value of the program and, especially, because of the social workers representing these programs. Typically, social workers were seen as a bridge to social and health care services. Mothers referenced the following case management services as particularly helpful: application assistance, bus passes, appointment support, and translation services. For example, Linda reported that when she had to apply for disability for her child, "[a social worker] signed me up and did the paperwork and stuff for me and sent it off." Another mother, Karol, received travel assistance, which allowed her to get medical care for her daughter's skin condition: "[My child] had to go to the University of Miami, to see the dermatologist out there.… They helped me get the bus pass, the train thing you pay for."

Mothers also reported and expressed appreciation for the parenting information, emotional support, and concrete services (e.g., clothes, car seat, food, toys, bassinet) provided by program workers. Linda, mentioned earlier, felt especially indebted to a case manager at the Hugs for Kids program: "Whatever I need like the bassinet, baby bed. I tell her and if they got it she will bring it.… I wouldn't have nothing if it weren't for them." Other mothers expressed similar gratitude: "I learned a lot from them." "She gave me good advice." "They told me they would help me and they did." "I feel very good with them." "She helps me out a lot."

When Sandra was pregnant with her first child, she applied for WIC, and a nurse at the WIC office referred her to the Healthy Mothers/Healthy Babies program. She telephoned the agency and received a follow-up letter. After giving birth, she was visited by a liaison from the program who gave her information on parenting and community services. She also was referred to the Healthy Start program and received several visits from a Healthy Start nurse, who also helped her obtain Medicaid for her baby. Her experience with the Healthy Start program left her

with a very positive view of the program. As her narrative below indicates, in addition to assistance in applying for Medicaid, the Healthy Start nurse also provided her with needed emotional and informational support as well as concrete resources.

> I really liked my nurse. She was a real older lady, but she knew a lot about mothers and babies. She used to comfort me a lot 'cause I used to have low self-esteem. She used to always ask me why do I feel like that? When you have a caseworker like that come to the house, you always tell everything. It always started with DeAndre's father not being in his life and my life. She used to bring me little videotapes that I could watch and [learn] things. She used to bring me things for DeAndre, baby clothes, bibs, and socks. For Christmas, she put me in this program where my name was drawn for a gift for the baby, and somebody that didn't even know me bought a big teddy bear and a car seat and some onesies. … She really comforted me a lot and what it really was somebody I could talk to about my problems so I just could get it out my mind. If I had a chance to let anybody know about that program, it is nice and will help you out a lot. It will take all the stress off you ... I shed a lot of tears in front of her. She [also taught me] how to put him to sleep, how to burp him, how to feed him, what kind of games to play with him, what kind of books to read to him.

The administrative and survey data indicate that only a small number of mothers in the study sample received mental health services, counseling, or other kinds of social services. Elizabete, a 25-year-old Hispanic mother of one child, was referred to the Children's Case Management Organization (CCMO) because of postpartum depression brought on, in part, because her baby had been born prematurely and had to remain in an incubator at the hospital for 5 weeks until he gained weight and could eat on his own. As she told us, she did not realize that she was depressed at first:

> They sent me a nurse when I had my baby to see how everything was, and the nurse saw that I was very depressed. And it was then that they looked for a psychologist for me because she said I needed one. And maybe I did, but I did not realize it. And they sent me to the psychologist; and they sent her from St. Mary's.

Like other mothers, Elizabete expressed satisfaction with the help she received from both the psychologist and a caseworker who was assigned to her and came to the house to ensure that her son had his concrete needs, such as baby wipes and shampoo. Indeed, in contrast to experiences with health and economic services, mothers who spoke about their experiences with care coordination and social services rarely reported specific program barriers in their narratives.

The value ascribed to social workers was captured by mothers' descriptions of the strategies they used to access services they lost. Some mothers', particularly immigrants, connections to services seemed more fragile, and they struggled to access services through conventional means; for them, social workers were their main link to community resources. Four immigrant mothers talked about returning to a hospital or clinic where they had previously received help to look for a social worker—or a particular worker who had helped them in the past—for assistance in reapplying for health care benefits for their children. An example is Tatiana, who was unsuccessful in reinstating Medicare for her daughter, Julia, on her own. According to Tatiana, "I have to go back to the hospital to

apply for Medicaid. My sister says that it is easier there than in the office. The social worker works there and she does the interview and that's it." For Tatiana and other immigrant mothers, a social worker can help them overcome the cultural, language, and technological barriers and expedite the application process. Tatiana's response to a computerized application process, for instance, was to return to the hospital social worker: "She [social worker] receives everything on paper."

In a few cases, mothers described experiences with care coordination services across the three waves of interviews. These mothers were among those who received intensive care coordination after the birth of the focal child and who had life circumstances that warranted continuous support services. Lariza, a 28-year-old Guatemalan mother of three, illustrates the role of social work services in conditions of persistent economic and social instability. Both Lariza and her husband (Carlos) are undocumented immigrants, with little or no education and an unsteady income. In the last two years, the couple moved three times due to financial strain and crowded housing conditions. The family was further destabilized by Carlos' unexpected job loss. The husband erupted in physical violence against Lariza, and the children exhibited increasingly aggressive behavior. Throughout these difficulties, Lariza received monthly home visitation services through the Healthy Beginnings system. The social worker, Ms. Gomez, was originally referred to Lariza and her family through St. Mary's Hospital. Over the last two years, Ms. Gomez has assisted Lariza in obtaining Medicaid, WIC, food stamps, bus passes, and psychotherapy for the children. Overall, Ms. Gomez has been a significant source of stability and continuity during these tumultuous years.

> Thank god she [social worker] helped me with my children.… She asks me if I am ok, if I need anything. And this month she came to give me clothes for the children, a bicycle, she brought me a dining room table for the children, she brought them gifts, toys. She is a good person.… She comes each month. When I need something I call her. I have her phone number and I call her.… If I receive a letter, I tell her. I can't read and she helps me read it.… She always comes.

Only two mothers described negative experiences with social service providers. For example, Nia, a 23-year-old African American single mother of two, tells a particularly unpleasant story about her experience with the Healthy Mothers/Healthy Babies Coalition. Nia sought help from this agency during her second pregnancy, following her caseworker's suggestion. However, while at the agency, Nia felt the worker was prejudiced toward her because she was lectured about African American single mothers and rates of low birth weight: "She said black females, we have low birth [weight] babies because we want to decide to smoke and drink before we go to the doctor and all this and that stuff. I mean she really peeved me off." Nia also felt targeted because she had a DCF record: "I am thinking I am going to get help. When I got there, she had to call and see if I had an open DCF case and all that kind of stuff.… I was more like dealing with [DCF] than dealing with Healthy Mothers/Healthy Babies.

Another case was Amanda, who described a particularly painful experience with an unsympathetic service provider when trying to collect toys for her children distributed by Salvation Army during December holidays. She had been unsuccessful the previous year, ostensibly because she did not have the proper documentation. However, despite her husband's

disapproval, she was determined to try again and hopeful that this time she would be able to obtain Christmas gifts for her children.

> The lady is Hispanic, the same as me, and I got her last year and this. I went at 8 in the morning, and I asked what they were giving. And she said, "Look at that paper that is outside." And I saw the paper on the door that said they were giving [toys] for the kids, so I took all the papers they asked for. And there were a lot of people, a long line. All the people went through, and I ended up right at the door. And I was just at the point to enter when they closed the door. And they told me I had to wait until 1, that it was lunch time. And later, I went in at 1. And I got stuck with the same lady that was signing people up for the gifts. I was saying to myself "I hope that I don't have to get stuck with that lady," but I did get stuck with her. I didn't like the treatment, because she said to me, "If you don't have a [social security number], why do you come here?" On the door it says that everyone has to have a SSN, but the kids have a SSN. I don't have a SSN. "If you don't have a SSN, then give me your residency." But I don't have residency, the gifts are for the kids. So [she said], "You can't." But I don't know why only she is that way ... because there were a lot of ladies who went in with me, people [who] applied without a social security number or anything. I sometimes say, "Why me?" I need it. I have four kids, and there are sometimes people there that lie, they give them gifts, good gifts. And me with my papers and telling the truth and she didn't give me anything.

Thus, once again, Amanda returned home empty-handed and disheartened. Her narrative reflects not only her disappointment in not having received gifts for her children but also her dismay at having to admit her failure to her husband again:

> I practically came out crying because all day long I left my kids, and they had told me yes, that they were giving there, that you didn't need anything (documents). Their father wasn't working then, and he didn't want me to go. He said, "No, don't go, because I think they aren't going to give you anything. You also went last year.' But I told him, "Maybe now they will. I won't lose anything. You stay here with the kids, and I'll go." So I made the food for the kids and everything, and I went. And when they told me "no," and I went out walking, I was crying, and I said, "Now what do I say to him?"

Except for Nia and Amanda, mothers who talked about using care coordination and social services reported positive experiences. Indeed, in contrast to experiences with health and economic support services, mothers who spoke about their experiences with care coordination and social services rarely spoke about barriers to using these services. Social service workers and home visiting nurses provided a range of services, including referrals to other services, parenting information, emotional support, and concrete services (e.g., clothes, car seat, food, toys, bus passes). Sandra also alluded to the fact that receiving these services in her home may have been another positive factor that facilitated her participation in the Healthy Start program.

Childcare Assistance

In this section, we focus on the issue of childcare affordability and childcare assistance. Survey data showed that by the third year of the study, almost half of the mothers were using some form of childcare, with center-based care and relative care reported most often. Again, use of childcare was driven largely by mothers' needs for care when they went to work and was influenced by the availability of different childcare arrangements in their communities (e.g., the increasing availability of center-based programs such as Head Start and pre-kindergarten for 3- and 4-year-old children). In addition, the qualitative data suggest that their choices of care were influenced by a combination of individual factors, including financial and social resources; work status and schedules; knowledge of the childcare options in their communities; child's age, development, and health; attitudes and beliefs about who should care for their children; and views about the social and educational benefits of childcare or preschool. All of these factors co-vary with another important influence on childcare decisions, namely, the cost of care relative to family income and access to childcare subsidies and other resources to assist with the costs of care.

The primary resource for financial assistance to low-income families is the childcare subsidy system, which is funded through the Childcare Development Fund (CCDF), a state block grant program created as part of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act to consolidate several childcare funding streams.[69] However, the CCDF is a capped entitlement program, meaning that it is not funded at a level to meet the childcare needs of all eligible families (Lowe & Weisner, 2004). Thus, although some states report under-utilization of their subsidy programs, there are many states—including Florida—with long waiting lists for subsidized childcare slots (NCIC; Shlay et al., 2004). In Florida, priority for limited childcare funds is given to several groups, including children at risk of child abuse or neglect, children of teen mothers, children of migrant farm workers, and children in families with a family income of less than 100 percent of the federal poverty level (CSC, 2008). As of March 2008, a little more than 6,000 children under 5 years of age were receiving subsidized childcare in Palm Beach County. However, about 3,000 eligible children were on a waiting list for subsidized care (CSC, 2008).

It is not surprising, then, that the cost of childcare was a recurring theme in mothers' accounts of their childcare arrangements. According to the survey data, less than half (43%) of the families in the study sample who were using non-parental childcare received financial assistance to pay for that care in the third year; 30 percent reported receiving a subsidy through Family Central, the agency responsible for administering the childcare subsidy program in Palm Beach County. Another 13 percent obtained help from a social service agency, a friend or relative, or, in two cases, an employer. More than two-thirds (69%) of the mothers who received a childcare subsidy through Family Central used it for a center-based care arrangement. In contrast, among the group of mothers without a subsidy, more than half (60%) were paying relatives or friends to care for their children, and just under a quarter (24%) of the mothers were using a center-based program.

[69] There are other public supports for childcare, including tax credits and income tax deductions for childcare costs, and educational programs, such as Head Start and state pre-kindergartens, provided at little or no cost.

Indeed, most of the working mothers in the qualitative sample cited cost as one of the main barriers to childcare centers. Some of these mothers were on a waiting list for a childcare subsidy, and others reported not being eligible for subsidies. In order to defray the cost of childcare, these working mothers usually use relative care, care by a friend or neighbor, or alternate working hours with their partners. Mothers also were highly aware of the incongruence between their wages and the cost of childcare. As Tracey, a 19-year-old mother with two children, put it, "that's my entire paycheck every two weeks," when explaining why she split-shift childcare with her partner instead of using day care for her children. Similarly, Teresa, a Honduran mother of two children, explained: "It was $200 that I earned, but, imagine, now I'd have to pay $80 or $100 for the girl for day care. And what can I do? It would be very little [what I have left]." In the third qualitative interview, Teresa reiterates, "Yes, the [day care center] is very expensive.… Because I am going to pay $120 and I am going to earn $180 or $200, what can I do?"

Maria, a 36-year-old mother of three children, wished she could place her young twins in a day care center when she returned to work. In her first qualitative interview, when the twins were about a year old, Maria reported that she had contacted Family Central but was informed she needed to be working to be put on a waiting list for a subsidy. This amounted to what might be described as a "catch 22" for Maria, who did not fully understand the program or its requirements.[70]

> [Family Central] told me that they also give some help, I don't know if it is through the government or where I should apply. But they said that I should be working and take the checks from what I had worked, but supposedly to work I need someone to take care of the babies. So, I don't see a way that they can help me to register them in a day care, which is what would be the best for me because it is two children. If I have to pay for an individual person, it is too much.

Without the help of a subsidy, Maria knew that a formal childcare arrangement was off limits to her: "Either family childcare or day care charges me too much. I will not earn [enough] money."

Six months later, Maria was working but still was unable to afford a formal childcare arrangement for the twins and had arranged for a neighborhood caregiver. Although she had completed the subsidy application at Family Central, she was on the waiting list. Maria had also visited a number of childcare centers, but it just confirmed what she already knew: "If I don't have some kind of help, I don't think I can pay for day care." Maria also talked about the hidden costs of a childcare center: "First, you have to pay money to apply.… And then what they charge weekly, if the baby gets sick on Monday, I have to pay the week even if the baby does not go in the whole week. I can't work. So it is a lot of money that they charge." One year after her first interview, Maria's neighborhood caregiver could no longer care for the twins. Fortunately, Maria's sister-in-law offered to take care of the twins for $200 a week. Although Maria

[70] In a recent article, Shlay and Weinraub (2008) also use the term *catch-22* to refer to the requirement of welfare-to-work policies that require people transitioning off welfare to have a job already in order to get a childcare subsidy. They also report that families who used childcare subsidies were more likely to still be in the workforce after leaving temporary assistance than families who did not.

continued to express frustration with the cost of childcare ("I have to pay a lot for them"), she also was pleased to be working: "I feel different when I go to work.… I learn things.…"

Marta, a mother of two children ages 8 and 2, contacted Family Central but did not qualify for a childcare subsidy. She seemed puzzled by, if not a little suspicious of, the income threshold:

> I said half of what I make goes to day care. So how can you assume the other half is gonna give me enough to pay rent, clothing, food, and everything else? Impossible! But I don't know. I said really, honestly, that's one thing I don't understand. They said that they have like a chart and they go based on whatever you make and if you qualify on that.

Marta also cast doubts on Family Central's ability to help her in a timely manner, even if she did qualify, because "basically by the time you get [the subsidy], you won't even need it anymore."

Shirley also complained about the requirements of the subsidy program, which expected her to volunteer in the community or attend job training if she did not have a regular job. She explained that she was not willing to volunteer at the childcare center when she herself needed to work "at a job where I can get a paycheck." Shirley also criticized the application process and the fact that children could not accompany their parents to appointments at Family Central:

> Like tryin' to fill out all these papers, they take you through too much just to get somethin'. They take you through a lot. Like around the time I was gettin' my kids in day care, luckily my baby daddy was here 'cause he was the one keeping them while I was goin' to all this [program] orientation, goin' back and forth, taking these papers back and forth to this place, this 'n that …. And when you go to these appointments, they don't want you to bring your kids. We coming to get help to put our kids in day care. Y'all don't want us to bring our kids to the appointment. So who's suppose to keep them?

About a dozen mothers in the qualitative sample talked about experiences trying to obtain childcare assistance through Family Central during the first three waves of interviews. Approximately half of this group received a subsidy at some point during this 12- to 15-month period. However, it appeared that most of these were only for a short period of time, which ranged, according to the mothers, from 10 days to 6 months.[71] These short durations may reflect not only the rules and limitations inherent in the subsidy system but requirements of other programs. For example, in the case of Miriam, whose story was presented in Box 2, the issue

[71] This observation could be an artifact of the data available at the time of this report for the qualitative sample. It needs to be verified with additional analysis of survey data over time as well as analysis of data from the childcare subsidy system. The survey data indicate that about three-fourths of the mothers who reported having a subsidy at year 2 also reported having a subsidy at year 3, which implies more continuity of use than the qualitative data imply. However, the survey data for the first 3 years of the study only provide information on subsidy use for mothers currently using childcare at the time of the interview. In future data collection, we will ask all mothers whether they have applied for a subsidy or are on a waiting list, if they are not currently using one; we also will look for patterns of subsidy use in the administrative data.

was a DCF funding time limit. According to Miriam, DCF set a 6-month time limit for the childcare subsidy. Therefore, when the time period specified expired, Family Central discontinued Miriam's childcare subsidy, even though she met the work and income requirements. Without the subsidy, Miriam could no longer afford childcare. Miriam was placed on the waiting list and had no other alternative but to leave the twins in the care of her unreliable former partner.

> I actually did speak to [Family Central]. I said, "I sent you the letter. You asked me to send you a letter that I'm working, and that you'll continue to pay if I'm working." She's like, "If DCF decides not to continue it, then we can do nothing about it." So I guess DCF didn't continue, and now I'm back on the waiting list.

The circumstances of the mothers in our sample who received a subsidy seemed to merit priority in getting help, which is consistent with the priority given to mothers with various risk factors in the subsidy program. They were typically TANF and Work Force participants and/or mothers who, like Miriam, had had contact with the child welfare system. In addition, these mothers were usually assigned a caseworker who facilitated their access to the childcare subsidy program. For example, Norma, a 22-year-old mother of a 2-year-old, was linked to Family Central through her caseworker when her child was about 18 months old:

> I had a caseworker working with me. I didn't really know about [the subsidy program] until she somehow got a hold of me to put him in day care while I was working, and I just said "okay" since I didn't have nobody to take care of him while I was working. So I really haven't looked into Family Central. I think it's mostly day care, though. They help…. But I guess they have case management going on with them, or they have people coming … I don't know how it was they got in touch with me. But you know how you fill in papers and stuff like that and they send them. Somehow, the next day she called me and she asked me could she come interview me, or something. And I said, "Sure." She's like they're doing something like a survey. But then she started asking me if my baby needed day care, and I said "yes." And she got me into Family Central, and she got me into this school.

Thus, most of the barriers to participation in the childcare subsidy system appeared to be at the program level and included program requirements (e.g., eligibility, paperwork, working status, income), program resources (e.g., funding), and waiting times for service (i.e., length of time on a waiting list). These barriers are consistent with those described in other literature on childcare and subsidy use (e.g., Chaudry, 2004; Gennetian et al., 2002; Lowe & Weisner, 2004). Chaudry's (2004) longitudinal study of childcare use by low-income working mothers in New York City details the same kinds of challenges and worries mothers in our study face in making ends meet with low-paying and insecure jobs and in finding quality childcare that is also convenient and affordable. He states the following:

> Low-income mothers cannot afford to pay the market costs of childcare, and there are not enough subsidies to help very many of them access quality care. In addition, the complicated childcare systems created by state and city governments to administer and ration childcare make it difficult for even the savvy and diligent to use them, and the immediacy of most job choices available to low-income women do not afford

them the patience or flexibility needed to negotiate those systems" (Chaudry, 2004, p. 12).

Although we need additional data on the stability of subsidy use for eligible mothers over time, the first three waves of qualitative data indicate at least three groups who sought or had contact with the subsidy system: One was a group of mothers who received a subsidy—typically, only with the intervention of another agency or social worker—for what appeared to be an indeterminate period of time; another group included mothers who qualified for a subsidy but were put on a waiting list; and a third group was made up of mothers who could not make it to the waiting list because, as in the case of Marta, they were over the income threshold, or because they were not yet working. For mothers in this last group, the need to be employed for a period of time before qualifying for a subsidy simply was problematic. From a program standpoint, the requirement was necessary to verify a mother's eligibility for the subsidy, but mothers could not understand how they could start a job—or, for some mothers, even look for work—without prior childcare arrangements.

Despite the instability that fluctuations in subsidy use can cause in families, the survey data indicate that a majority of the focal children in the study appear to have experienced relatively stable childcare arrangements during the first 2 to 3 years of their lives, meaning they have received care in only one or two different arrangements. On the other hand, close to half (46%) of the children had two or more transitions in care, and almost one-quarter (24%) experienced three or four transitions.

Housing Assistance

Overcrowding, cost of rent, physically inadequate housing conditions, and unsafe neighborhoods can make it difficult for families to achieve a nurturing and stable household environment for their children's well-being and development (Brooks-Gunn, Duncan, & Aber, 1997a; Brooks-Gunn et al., 1993; Elder et al., 1995; Federal Interagency Forum on Child and Family Statistics, 2008; Vandivere, Gallagher, & Moore, 1994; Wood et al., 1993). Survey data indicate that less than 10 percent of the study families reported assistance with housing in the first 3 years, with just 4 percent reporting use of housing services (e.g., a Section 8 housing voucher, public housing, or emergency shelter) in the first year, and 8 percent in the second and third years. In a related area of assistance—help with rent or bills—the percentage of mothers receiving assistance was only slightly higher (11% in year 1, 10% in year 2, and 9% in year 3). Receipt of housing assistance was more frequent among high service users. Almost a third (32%) of the group of mothers using five or more services in the previous year received assistance with housing, whereas only 5 percent in the group of mothers using three or four services and no one in the group of mothers using fewer than three services received assistance with housing.[72]

The percentages of mothers in the qualitative sample receiving assistance paralleled those of the larger sample from which they were drawn; for example, just five mothers in the qualitative sample reported housing assistance in the first year, and only three mothers in the third year. However, this did not mean that other mothers did not need or did not try to get help

[72] Nearly all (90%) of the mothers who received housing assistance in year 3 were U.S.-born and had two or more children.

with their housing. Indeed, adequate and affordable housing was a salient concern for more than half of mothers in the qualitative study sample; across the first three waves of the qualitative study, twenty-eight mothers talked about their struggles to pay rent and utility bills and to improve their living conditions. They reported a variety of strategies to cope with harsh economic times. Some—particularly immigrant families—tried to reduce housing costs by doubling up with family members or friends, or by finding other tenants to share living space and rent. Other families coped by taking on second and third jobs to pay the rent. Others with limited financial resources and lack of housing options felt they had no choice but to remain in high-crime neighborhoods and poorly maintained housing.

Inadequate housing conditions, crowdedness, financial strain, and neighborhood environment were the main factors influencing mothers' decisions to seek housing assistance. Mothers who sought support for their housing and shelter needs looked primarily to three types of services: Section 8, housing authorities for public housing, and the Federal Emergency Management Agency (FEMA) for shelter and housing repairs. The analysis of the first three waves of qualitative data suggests that most of the factors facilitating application for and/or use of housing services clustered around the individual level and were primarily tied to personal enabling resources. In particular, mothers who sought housing assistance talked about their needs, desire for independence, desire for a better environment in which to raise their children, knowledge of available services and how to apply, and life changes that made them eligible for services.

For example, Debra, a young single mother of 22-month-old Justin, explained that she was applying for Section 8 because one day she wanted to move out of the home she shared with her mother and needed the help of housing services to do so:

> [O]nce I feel like moving out from my mom [I'll need help], and these prices just steady going up around here, I might as well move to Palm Beach. Eventually [with] my little check I'm really not gonna have nothing to myself, especially when I'm trying to get a car right now. Then I'm gonna have a car payment and insurance. Then I got rent, lights, water, definitely a phone 'cause I got to talk. And then, you gotta fix up the place.

In the third wave of the qualitative interview, Debra told us she had made a deposit and paid the first month's rent on an apartment. Unfortunately, she was forced to postpone her moving plans when she lost her job as a consequence of an unexpected pregnancy. Without a stable income, Debra had no choice but to continue living with her mother, which devastated her: "I done lost my apartment, which was [the day] before yesterday. I never moved in. I never put nothing in there, nothing. Never moved in. That's crazy. Yea, I lost all that money—the deposit, the first month rent, all that."

Like Debra, Norma, a mother of two children under the age of 2, explained that for financial reasons she was living with her parents and not with the father of her second child. However, she was trying to change those circumstances by applying for a housing service: "That's really one thing (housing) I'm stressing 'bout. 'Cause I've been living here with my parents, and it's like you don't get the same privacy. So, so that's the only reason why me and

the father aren't really together, 'cause we're trying to work on getting our own place." Similarly, Sandra was reluctantly living with her child's godparents but thought that getting housing assistance would increase her chances of getting a place for her and her son, DeAndre:

> Now if I can get housing, I can go on from there. I mean, I know I'll be able to pay my bills, I'm already saving up. And with housing you get a lot of help, you know. And that's what I'll be looking forward to. I mean, sometimes you can depend on everybody, and people won't help you if they don't see you help yourself. And I just wanna get my own place.

Having a place of her own to share with her partner and children has also fueled Tracy's persistence in seeking housing assistance. Although Tracy encountered many barriers related to program eligibility and guidelines, she did not give up easily. In the first qualitative interview, Tracy explained her three failed attempts to apply for Section 8:

> I thought the food stamps [application] was complicated, but the housing thing is really complicated. I don't know if it's the same company, but I've applied for that twice. The first time I applied, they said that I was too young. Because my grandmother's on housing, so her worker told me to try to apply and by the time I was 18, I applied there and they said I was too young, and then they said that the landlord wouldn't rent to me because I was too young, which I didn't understand because I know people that are 16 or 17 on Section 8. The second time I applied, I guess because you have to have some type of source of income, they said that with me working and [my boyfriend's] income, it was still too high; and I still don't get how is your income too high for something, so I haven't applied since then. Well, the third time I applied, which was recently, they weren't accepting applications or something.

Despite her failure to receive services, Tracy decided to focus her efforts on other housing alternatives. In wave 3, Tracy told us that through a friend she learned about and applied for a low-income housing program. Tracy seemed to remain positive about her chances to receive housing assistance: "So they [program staff] say like within like the next two to three weeks I should know."

Although many of the study families suffered financial losses during the 2005 hurricane season, just two mothers attempted to get help from FEMA for damage to their housing. Neena and her family obtained a new trailer with the help of a FEMA representative after their own trailer was severely damaged in a hurricane. Although she described the application process for assistance to purchase a new trailer as arduous, Neena was thrilled to receive FEMA's help and get a new home:

> Well, the people that came here helped me, but they called me on the phone, and I sent them things by fax or papers by mail. And they would say, "You know what, we need this, an estimation of how much your insurance is, an estimate, we need a check stub for your husband. We need this, this and that." … I did a lot so that they would give me that trailer.

On the other hand, when Brenda sought help from FEMA because of damage to her furniture and apartment, her application was denied. "I was mad they [didn't] help us," she said. "I didn't feel like that was right because our stuff got damaged. They didn't apply for us. They turned us down. [They didn't give us a reason.] They just said it was being denied." She went on to say that, in her view, "About half of 'em that didn't need it [in the Glades] got help, [and then] some of the people that did need it, didn't get it."

Although need and a desire for independence were the impetus for many mothers to seek housing assistance, some mothers were unaware of the availability of housing services or, if they were aware of them, they did not know they were eligible or how to apply. For example, Clarice, a mother of one child, seemed to know relatively little about housing programs in general: "I think there is one program. I am not for sure what the name is but I think they help people look for apartments and help them move in. I got to check that out." Other mothers knew of services but believed that they were ineligible and thus did not apply. For example, Elizabete, a Hispanic mother of two children, explained that she never applied for housing assistance because she did not work and her husband was undocumented.

Qualitative data suggest that mothers were more likely to apply if they had learned about services through their personal networks or an information service, such as the 211 hotline. Typically, mothers who had applied for housing services learned about programs and application processes through a friend, acquaintance, social workers, or family members who were familiar with the program. For example, Ana, a 24-year-old Hispanic mother of a toddler, gained entry to a public housing complex for agricultural workers through her father, who works in the sugar cane fields. Linda, another young mother, although not currently using any services, planned to consult her mother, who she viewed as her main source of information, about the housing application process: "I will probably ask my Mama, and she will let me know 'cause she finds out stuff like that. She will find out a lot of stuff, and she will let us know. She is the one that tells us where to go and how to do it and stuff like that."

In some cases, mothers decided to apply when something in their life changed and made them eligible for a housing service for which they had previously been denied. For example, when 20-year-old Denise, an African American unmarried mother of two young children, got a job, she reapplied to the Section 8 service for which she had been previously ineligible because of her unemployment.

> [I am going to] the main office so I can give them a copy of my pay stubs to let them know that I am working. 'Cause when you are working, your application gets pushed through more, because you have to have a job, you have to. They are getting strict now, because some woman they don't have a job but they have income still coming in from child support or the government, so you still have to have a job. If you don't have a job, you have to do community services but to get a place over here, you have to have a job unless you are elderly.

Whereas individual factors were the main facilitators in the use of housing assistance, the barriers to housing assistance were distributed across individual, program, provider, and community levels. Lack of knowledge about services, program requirements and guidelines,

program financial health, provider responsiveness, transportation, housing quality and location, and cost of housing deposit were some of the major barriers discussed by mothers. Several mothers in the qualitative study who talked about the desire to improve their living situations saw a Section 8 housing voucher as the only way to do this. These mothers made a clear distinction between Section 8 and public housing assistance programs; for them, Section 8 meant choice, better neighborhoods, and superior quality of housing, whereas public housing usually meant lack of choice, unsafe neighborhoods, and poorly maintained housing.

Thus, some mothers did not apply for public housing assistance because they believed it did not offer acceptable housing options. They explained that the housing service would require them to move to an area far from where they currently lived or would place them in a troubled neighborhood with inadequate housing conditions. Angelica said she was considering applying to a public housing authority because she would "get a lot of help" through it, but she feared the areas where she and her children would have to live if they received this assistance:

> My mom she's on housing. One day I went with her down to the Housing Authority. She had an appointment and I told her to ask her caseworker was they accepting any applications, and they said, "No, we're not accepting any applications until a year." And I don't wanna go far out, like Delray, Boynton, Lake Worth. I don't have a car to get way out there. It's a bad neighborhood, and I don't wanna live there. They have their own housing, but then you have to stay in that area for a year until you can move. And I don't feel that I'm safe if I was to move there because it's too much drug activity. I'm afraid that one day I might come home and somebody been don' broke in my house and took my stuff. I probably wouldn't even be able to sleep if I was to move out there. I'd be up looking out the window all day. I wouldn't feel comfortable at all knowing that I live there and I can't get no sleep cause I'm afraid that somebody might break in my house. And I don't like it up there. I'm scared.

Provider and program factors were strong barriers to housing assistance. Based on previous experience or reports from friends and relatives, a number of mothers simply did not apply or gave up trying to apply because of complex application processes, lengthy waiting times, or previous rejections of applications. According to Sandra, long waiting times and an overabundance of applicants had kept her from receiving housing assistance:

> I tried so hard to get housing. I can't remember which village apartments, off of Military Trail. They was accepting applications [but] it was like so many people was trying to get housing. And I went, but, I mean, I never got a call back or anything. Housing is a lot of waitin'. Some people wait a year to actually get housing. I mean, if you fill out an application, why can't we just, you know, get help right then and there? Why do we have to wait a year? But I realize that it's so many people tryin' to apply for it that they have no choice but go through, you know, package by package."

Denise expressed the frustration of many mothers who described the unpredictability and uncertainty of the process of applying for a Section 8 voucher:

> I have been trying with Section 8, but every time I find out that they are doing applications, it is at the last minute. 'Cause what they do is send out a thing saying, "We are accepting applications today in the morning from 9 to 2 o'clock'." [Int.: Where do they send it out?] I have no idea. There are so many different places and then they keep changing.

Denise went on to say that she decided it was not worth the effort and time to try to apply: "When you find out (they are accepting), it is the last minute, and you don't have all your papers ready, or you don't have a lot of information, or you can't get there, or when you get there, the line is too long or something, so I just don't worry about it."

Provider behavior was also a contributing factor constraining service use. Several mothers believed that housing program staff members were rude and unhelpful. In the excerpt below, Latoya, an African American mother of five children ranging in age from 2 to 13 years, described how she had been on the waiting list for Section 8 for approximately five years, had received little help from provider staff, and became too frustrated with the process to continue:

> I applied for [Section 8] one time … a long time, about 5 years ago. They still [have me] on a waiting list. It take too long. [Int.: Do they keep in touch with you? Do they send you a letter every now and again?] Nope. [Int.: Or do you call them once a year?] I don't bother callin' no more. I used to call them all the time. [Int.: And were they friendly?] Not to me, they wasn't. They'll tell you, "call back … whenever we got openings." Like I know when they've got openings. [Int.: And so after how long did you stop calling back?] Well, ever since last year.

Likewise, Sabrina, an African American mother of a toddler, explained that she would not use the public housing authority because they give people "a hassle": "They give you a hassle. They play a lot of games. Everybody says that nobody [uses] Delray housing anymore. Play too many games and give you the run around and everything." Unlike Latoya, though, Sabrina was a mother who had previously been identified "at risk" for possible child abuse or neglect because of mental health issues and had a caseworker assigned to her to expedite her access to services. As a result of her caseworker's efforts, she was able to apply for and receive help from the Section 8 housing program.

Of the qualitative sample, then, just a handful of mothers actually received assistance with housing. Most of the mothers in the sample either tried to obtain housing assistance but were unsuccessful or did not try. Over the first 3 years of survey data and first three waves of qualitative interviews, use of housing services was limited to less than 10 percent of the sample. The individual factors that prompted mothers to apply for housing services included financial need, a desire for independence from parents, and the desire to provide a better neighborhood and home for children. There was only one case in the qualitative sample of a mother receiving assistance from a caseworker, who was able to expedite her application for a Section 8 housing voucher.

Mothers who did not try to apply for housing services were constrained by a variety of individual factors, including their beliefs about program requirements and eligibility. Other

barriers emerging from their narratives included knowledge of housing services and guidelines, beliefs that housing services are difficult to obtain, and the belief that the service does not offer acceptable housing conditions. For mothers who applied (or tried to apply) for services and did not receive them, most barriers were located at the program level. Waiting time; non-acceptance of housing applications; unpredictability of application acceptance, program requirements, and eligibility; and provider responsiveness were some of the main barriers inhibiting housing service use. Income, employment status, mother's age, credit history, and number of household members were among the most commonly cited eligibility requirements inhibiting mothers' use of housing assistance. As illustrated by Tracy, who was told, alternately, that her age and income were reasons for rejecting her first and second application attempts, sometimes the multiple eligibility requirements seemed totally confusing.

Summary: Emerging Themes in Families' Service Experiences over Time

The focus of this chapter has been on the service experiences of families in the TGAs, and barriers to and facilitators of their service use, based on an analysis of the first three waves of qualitative interviews in five areas of service use—health care, food assistance, childcare, social services and community support, and housing assistance. Consistent with the survey findings, mothers in the qualitative sample reveal different patterns of service use both within and between these service areas. These patterns of service use were influenced by individual factors such as their financial needs, knowledge of services, personal beliefs, language and literacy skills, desire to provide a healthy and stable environment for their children, the availability of social support, and their own persistence or ability to advocate for themselves with service providers. Their service use was also influenced by provider, program, and neighborhood factors: for example, program eligibility and paperwork requirements, the ease or difficulty of the application process, the location of agency offices, the responsiveness of office staff, and waiting times for services.

Mothers experienced these service facilitators and barriers in different ways, depending on their personal characteristics, family circumstances, and neighborhoods. For example, although the online application process for Medicaid, food stamps, and WIC appealed to mothers who were computer literate, immigrant mothers with limited English or literacy skills found it particularly difficult—especially in offices without bilingual staff or staff who were willing to help them with reading and writing. Recent immigrants also were more likely than other families to lack knowledge of the services for which they were eligible or to have erroneous beliefs about using these services; for example, some hesitated to apply for some public assistance programs for which they might have been eligible because of fears that they would jeopardize a parent's application for residency or their child's future wages. Native-born mothers, on the other hand, because they were less likely to be married than immigrant mothers, faced different kinds of barriers in using public support programs; in particular, they complained about the need to file for child support to obtain food stamps, which created conflicts in their loyalties toward partners who were providing for them and their children.

Many of these factors were evident in our preliminary analysis of mothers' service experiences in the first two waves of qualitative data. The addition of the third wave along with additional survey data on declining service use in some areas, such as food assistance, provide

evidence of other barriers that were not apparent earlier. In particular, we find mothers missing appointments to recertify their public benefits, forgetting to bring their children with them when they went the WIC office, thereby interrupting their food assistance, or abruptly losing a childcare subsidy and having to scramble to make other arrangements. We also see how fluctuations in their daily lives—for example, a new job, the loss of a job, transportation problems, a family illness, a partner with a substance abuse problem, or an unexpected pregnancy—can suddenly change their eligibility for a service or ability to keep up with appointments as well as their ability to care for their children. Although many mothers can count on their personal networks of relatives and friends in emergency situations, these social support systems can be fragile and be another source of instability in their lives.

Moreover, the qualitative data suggest that the process of applying for and recertifying services can be as much a source of stress as the services are a source of help. Sandra, quoted at the beginning of this chapter, said: "It's help, it's a lot of help. But it's just the stuff you gotta do to get help." Applying for programs that offer limited help for families that are constrained by their education and language background adds to the complexities of families' daily routines. Families need to allocate a significant amount of time and energy in order to follow through with providing the documentation needed to apply for a service, to drive to the program office, to find someone that could help them communicate their needs or operate a computer, and to comply with other program requirements. As some of the mothers in the qualitative sample related their experience with services, it was apparent that the more barriers there are to a program, the more complex the families' routine becomes. Paradoxically, programs that should help stabilize families' lives seemed to be the ones that added to the instability of their daily routines. Although the individual, program, and provider barriers associated with health care and food assistance may not keep mothers from using or trying to use them, the process of getting services may add (or be perceived to add) stressors to family routines and circumstances.

Finally, a recurring theme in the longitudinal data thus far is the important role of social workers and case managers in connecting families to needed services that they might not be able to access on their own. This was a clear finding across all of the service areas addressed in this section. Although these providers often were a source of other services—parenting advice, mental health services—they also were an essential bridge or "broker" between some mothers and basic services, including Medicaid, food assistance, and childcare subsidies. A number of mothers talked about contacting social workers in the hospital where they gave birth or at another agency for assistance in reapplying for public services. This finding of the potential importance of social workers for connecting mothers to economic support and other services suggests the need for expansion of case management services for mothers who are not necessarily "at risk" but who need assistance in maintaining their services.

SERVICE USE AND OUTCOMES: MATERNAL FUNCTIONING AND CHILD DEVELOPMENT

It has frequently been noted that effective parenting and child well-being are often impaired by the stresses associated with living in poverty (Bradley & Corwyn, 2002; Duncan & Brooks-Gunn, 2000; McLoyd, 1998). It has also been suggested that society may be able to improve the outcomes of children living in poverty by bolstering the level of support available to them and their parents through the provision of public services and supports (Attree, 2005). This conclusion stems, in part, from evidence that social support, both informal and formal, is an important resource for poor parents (Attree, 2005; Henly et al., 2005). Building on this idea, comprehensive, integrated service systems have increasingly been viewed as a promising strategy for supporting healthy family functioning and child development in low-income, at-risk families (Brooks-Gunn, 2003; Gomby, 2005; Olds et al., 2007). However, although there is a sizeable body of literature focusing on the effects of specialized services and interventions for children and families, we are aware of only one study to date that has attempted to assess the impact of families' use of comprehensive services (Leventhal et al., 2000).

The Palm Beach County longitudinal study provides a unique opportunity to understand the potential consequences of mothers' use of services, in the broadest sense, for their families' well-being. Accordingly, in this final chapter, we consider how mothers' overall service use is related to their own and their children's outcomes. The maternal outcomes that we consider include depression, parental stress, and positive and negative parenting practices. For children, we consider the number of developmental milestones they have reached by the third interview and their level of language development, as evidenced by whether or not they are talking in complete sentences.

Maternal Depression

As described in Chapter 2, the Center for Epidemiologic Studies Depression Scale (CES-D) was used to assess mothers' depression symptoms. Scores on the CES-D can range from 0 to 60, with higher scores indicating the presence of more depressive symptoms, and scores of 16 or higher indicating the presence of some depression. In the third year, mothers' CES-D scores ranged from 0 to 52, with an average of 8.8. Also, 19 percent of mothers had scores of 16 or higher.

We first considered the ways in which mothers with and without depressive symptoms might differ from each other by comparing the year 1 and year 2 characteristics, and year 3 service use, of mothers in the two groups. The results of this analysis are presented in Table 83. They show that mothers with CES-D scores of 16 or higher used more services in year 3; however, the difference was not statistically significant. Pairwise *t*-tests did show that these mothers had significantly higher ($p \leq .01$) study risk indices and reported significantly more housing-related problems. In addition, *z*-tests showed that they were significantly more likely ($p \leq .05$) to be Black, and significantly less likely to be Hispanic and to be married or cohabiting. Consistent with the latter result, they also had significantly lower partner support scores. Finally, as might be expected, mothers with high CES-D scores were more likely to have

Table 83. Characteristics of Mothers by Depressive Symptoms in Year 3

	Depression Score < 16	Depression Score >= 16
Number of services in year 3	3.03	3.20
Baseline Characteristics		
Glades (%)	13	15
U.S.-born (%)	44	40
Black, not Hispanic (%)*	32	63
Hispanic (%)*	60	32
Education:		
HS grad (%)	25	23
Post-HS (%)	16	20
Teen mother (%)	17	25
Study risk index**	3.50	4.27
Year 2 Characteristics		
Number of children		
One (%)	42	41
Two (%)	34	30
Three or more (%)	24	28
Lives with husband or partner (%)*	70	54
Mother employed* (%)	43	57
Income at or below poverty (%)^	52	65
Target child special needs (%)	21	16
Other children special needs (%)	9	11
Other household member has health problem (%)	8	10
Number of housing problems**	1.14	2.14
Partner support score**	9.75	7.35
Family/friend support score	8.59	8.50
Stress index ≥ 86 (%)*	12	36
Depression ≥ 16 (%)*	19	45

^ $p \leq .10$, * $p < .05$, ** $p \leq .01$

had a parenting stress score above the clinical level in year 2, and to have had a CES-D score of 16 or higher in year 2.

Next, we conducted a logistic regression analysis in order to determine which of the aforementioned variables continue to be significantly associated with the likelihood of depressive symptoms, after taking into account possible correlations between the variables. The primary variables selected for the regression were those that were statistically significant ($p \leq .10$) in Table 83. In addition, we also included year 3 service use and residence in the Glades TGA as variables of special interest.[73]

[73] Also, because the partner support score is closely related to whether or not a mother is married or cohabiting, these two variables were entered in separate regressions. However, neither variable had a statistically significant coefficient. For simplicity, only the estimated coefficient for living with a husband or partner is presented in the results table.

The results of the logistic regression analysis are presented in Table 84. Consistent with the bivariate analysis, they show that the number of services used in year 3 is positively related to the odds of a mother experiencing depressive symptoms but is statistically insignificant. The most important predictor of the likelihood of depressive symptoms is being Black and foreign-born; the odds ratio for these mothers is almost 14 times as high as the odds ratio for Hispanic foreign-born mothers (the "excluded," or comparison, group). In addition, the odds for depressive symptoms are also significantly higher for mothers who were teenagers when they gave birth, and for mothers who experienced a greater number of housing-related problems. Finally, as might be expected, mothers with high parenting stress and depression scores in year 2 also showed higher odds of depressive symptoms in year 3.

Table 84. Regression Analysis of Likelihood of CES-D Depression Score Greater than 16 in Year 3

Independent Variable	Odds Ratio	Sig.
Number of services at year 3	1.06	*NS*
Glades	.901	*NS*
Race/nativity		
Black—U.S.-born	1.39	*NS*
Black—foreign-born	13.72	**
Hispanic—U.S.-born	.816	*NS*
Hispanic—Foreign-born (excluded category)	--	--
White/other	1.02	*NS*
Teen mother	2.74	*
Study risk index	1.15	*NS*
Lived with husband or partner (year 2)	.646	*NS*
Number of children (year 2):		
One	.605	*NS*
Two	.456	^
Three (excluded category)	--	--
Income at or below poverty (year 2)	1.43	*NS*
Number of housing problems (year 2)	1.27	**
Parenting stress index ≥ 86 (year 2)	2.45	*
CES-D depression score ≥ 16 (year 2)	2.96	**
Constant	.037	**
R^2	.35	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Parental Stress

The Parenting Stress Index Short Form (PSI/SF) was used to assess mothers' symptoms of parenting stress. Scores on the PSI/SF can range from 0 to 180, with higher scores indicating greater stress; a score at or above the 85th percentile, defined as a raw score of 86 or higher, is considered as indicative of clinically significant levels of stress. Parenting stress scores for

mothers in the year 3 sample ranged from 36 to 170, with a mean of 62.5. Also, 11 percent of the sample scored at or above the 85th percentile.

Table 85 compares the year 1 and year 2 characteristics, and year 3 service use, of mothers above and below the 85th percentile. The comparison shows that mothers with PSI/SF scores of 86 or higher reported using more services on average than mothers in the comparison group, and a *t*-test indicated that this difference was statistically significant ($p \leq .05$). This difference may be a reflection of greater need on the part of mothers with higher parental stress scores: for example, these mothers were also significantly more likely to have a child with special needs and to have had a CES-D score of 16 or higher in year 2. They also reported significantly more housing problems. In addition, as might be expected, these mothers were significantly more likely to have a parenting stress score above the clinical level in year 2.

Table 85. Characteristics of Mothers with and without PSI Parenting Stress Score Greater than 86 in Year 3

	Parenting Stress Index < 86	Parenting Stress Index >= 86
Number of services at year 3*	2.97	3.61
Baseline Characteristics		
Glades (%)	13	14
U.S.-born (%)	42	50
Black, not Hispanic (%)*	36	56
Hispanic (%)	56	42
Education		
HS grad (%)	25	23
Post-HS (%)	18	17
Teen mother (%)	18	19
Study risk index	3.57	3.98
Year 2 Characteristics		
Number of children		
One (%)	42	42
Two (%)^	34	21
Three or more (%)	24	37
Lives with husband or partner (%)	68	61
Mother employed (%)	47	45
Income at or below poverty (%)	53	56
Target child special needs (%)*	18	31
Other children special needs (%)	10	11
Other household member has health problem (%)	9	8
Number of housing problems*	1.22	1.80
Partner support score	9.35	8.91
Family/friend support score	8.54	9.03
Stress index ≥ 86 (%)*	8	43
Depression ≥ 16 (%)*	21	41

^ $p \leq .10$, * $p < .05$

Table 86 presents the results of a logistic regression analysis, which shows the variables that remain statistically significant after taking into account possible correlations among the explanatory variables. The primary variables selected for the regression were those that were statistically significant ($p \leq .10$) in Table 65. In addition, we also included residence in the Glades TGA as a variable of special interest.

The results show that, after controlling for background and other variables, the number of services used in year 3 is not significantly related to the odds of experiencing high parenting stress. This result provides some support for the interpretation that the use of more services among mothers with high stress scores, as shown in Table 65, might be a reflection of greater underlying needs among mothers with such scores; however, it should be noted that the number of reported housing problems, a potential indicator of need, is also statistically insignificant in the regression analysis. The variables that continue to be significantly associated with parenting stress levels are race/nativity, number of children, parenting stress in the previous year's survey, and having a child with special needs (although the latter is significant only at $p = .10$). Of particular concern, perhaps, is the result showing that the odds of a Black foreign-born mother having a clinically significant level of parenting stress are over five and a half times the odds for a Hispanic foreign-born mother.

Table 86. Regression Analysis of Likelihood of PSI Parental Stress Index Greater than 86 in Year 3

Independent Variable	Odds Ratio	Sig.
Number of services at year 3	1.13	*NS*
Glades	.67	*NS*
Race/nativity		
Black—U.S.-born	2.06	*NS*
Black—foreign-born	5.67	*
Hispanic—U.S.-born	1.80	*NS*
Hispanic—foreign-born (excluded category)	--	--
White/other	.19	*NS*
Number of children (year 2):		
One	.71	*NS*
Two	.38	*
Three (excluded category)	--	--
Target child special needs (year 2)	2.22	^
Number of housing problems (year 2)	1.13	*NS*
Parenting stress index ≥ 86 (year 2)	9.10	**
CES-D depression score ≥ 16 (year 2)	1.36	*NS*
Constant	.04	**
R^2	.30	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Positive Parenting Practices

For this section, mothers' positive parenting practices were measured by the proportion of positive responses to twelve positive parenting items; thus, the total score could range from 0 to 1.[74] The (weighted) mean positive parenting score for the year 3 sample was .74, with a standard deviation of .17. In order to get a sense of how mothers with relatively high scores compared with those with lower scores we compared mothers in the lower 25th percentile (or those with scores of .625 or below) with those in the upper 75th percentile. The results are presented in Table 87.

Table 87. Characteristics of Mothers by Positive Parenting Score in Year 3

	Positive Parenting Score in Upper 75th Percentile	Positive Parenting Score in Lower 25th Percentile
Mean number of services at year 3*	3.19	2.66
Baseline Characteristics		
Glades (%)	13	12
U.S.-born (%)*	46	31
Black, not Hispanic (%)	39	34
Hispanic (%)	54	59
Education:		
HS grad (%)*	28	10
Post-HS^ (%)	19	11
Teen mother (%)	17	22
Study risk index**	3.47	4.17
Year 2 Characteristics		
Number of children		
One (%)*	34	69
Two (%)*	38	19
Three or more (%)*	28	13
Lives with husband or partner (%)	68	63
Mother employed (%)	43	52
Income at or below poverty (%)	54	58
Target child special needs (%)	19	21
Other children special needs (%)*	11	4
Mother has health problem (%)	5	8
Other household member has health problem (%)	8	9
Number of housing problems	1.31	1.28
Partner support score	9.34	9.43
Family/friend support score*	8.9	7.5
Parenting stress index ≥ 86 (%)	16	19
CES-D depression ≥ 16 (%)	23	26
Positive parenting score**	.78	.62
Investigated DCF reports from birth to age 1 year (%)	10	8
Indicated DCF reports from birth to age 1 year (%)	6	5

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

[74] See Table 19 for a list of the positive parenting items in the year 3 survey.

In this case, we find that mothers in the upper 75th percentile for positive parenting used more services on average during year 3 than mothers in the lower 25th percentile; further, this difference was significant at $p \leq .05$. This result suggests that greater service use may be associated with more positive parenting outcomes; however, as in previous analyses, it is important to determine whether this relationship persists after controlling for other factors related to both positive parenting practices and service use.

We also found that mothers with more positive parenting scores in year 3 were significantly more likely to be U.S.-born, and to have significantly more education, lower study risk scores, higher family/friend support scores, and higher positive parenting scores in year 2. Interestingly, they also had more children, perhaps reflecting the effects of greater parenting experience and/or accumulation of parenting knowledge, or the help of older children with their younger siblings. In addition, perhaps contrary to expectations, mothers with higher positive parenting scores were also more likely to have a child (other than the target child) with special needs. However, it is possible that these mothers sought out and/or received additional services because of their child's special needs, and these services may have included parenting support or information.

We then conducted a linear regression analysis of the raw parenting score in order to determine which of the aforementioned variables remained significant after controlling for the effects of the remaining variables. We used the raw parenting score as the dependent variable because, in this case, there is no critical point indicating a clinically significant lack of positive parenting practices. As in previous analyses, we also included residence in the Glades as a variable of special interest.

The results in Table 88 show that the number of services mothers received during the year prior to the third survey continues to be positively and significantly related to the positive parenting score in year 3. This result provides some support for the view that provision of formal services might lead to improvements in parenting and, ultimately, child well-being.[75]

The results also show that, consistent with the literature on parenting, mothers with more education and more informal support have higher positive parenting scores. In addition, consistent with the bivariate analysis, mothers with fewer children have lower positive parenting scores. Specifically, the results indicate that mothers with only one child have lower positive parenting scores than mothers with three or more children. Finally, the results indicate that Black foreign-born mothers have significantly lower positive parenting scores than Hispanic foreign-born mothers. In previous analyses, we have seen that Black foreign-born mothers exhibit a higher likelihood of critical levels of parenting stress and depression. Although these variables were not significantly related to positive parenting for mothers as a whole, it may be that these variables specifically impact parenting among Black foreign-born mothers, further underlining the possible need to ensure that these mothers have access to relevant services.

[75] We also ran a regression in which we substituted receipt of help with parenting information for number of services used. However, although the coefficient on this variable was positive, it was not statistically significant.

Table 88. Regression Analysis of Positive Parenting Score in Year 3

Predictor Variable	Coefficient	Sig.
Number of services at year 3	.01	**
Glades	-.02	*NS*
Race/nativity		
Black—U.S.-born	-.03	*NS*
Black—foreign-born	-.06	**
Hispanic—U.S.-born	-.01	*NS*
Hispanic—foreign-born (excluded category)	--	--
White/other	-.05	*NS*
Education		
HS grad	.05	**
Post HS	.03	*NS*
Study risk index	-.01	*NS*
Number of children (year 2):		
One	-.05	*
Two	-.01	*NS*
Three (excluded category)	--	--
Other children—special needs (year 2)	-.01	*NS*
Family/friend support score (year 2)	.003	^
Positive parenting score (year 2)	.48	**
Constant	.379	**
R^2	.37	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Negative Parenting Practices

Mothers' negative parenting practices were measured by the proportion of positive responses to five negative parenting items; thus, the total score could range from 0 to 1.[76] The (weighted) mean negative parenting score for the year 3 sample was .24, with a standard deviation of .23.

In order to understand how mothers with relatively high scores compared with those with lower scores, we compared the characteristics of mothers in the upper 25th percentile (or those with scores of .60 or above) with those in the lower 75th percentile. The results, presented in Table 89, show that mothers with high negative parenting scores were significantly less likely ($p \leq .05$) to be U.S.-born and Black. They also had a significantly higher number of housing problems and higher negative parenting scores in year 2. The results also suggest that mothers with high negative parenting scores were more likely to be Hispanic and to be married or cohabiting, and less likely to have only one child or to live with a household member with health problems; however, these differences were only significant at the 10-percent level.

[76] See Table 21 for a list of the positive parenting items in the year 3 survey.

Table 89. Characteristics of Mothers, by Negative Parenting Score in Year 3

	Negative Parenting Score in Lower 75th Percentile	Negative Parenting Score in Upper 25th Percentile
Number of services at year 3	3.04	3.25
Baseline Characteristics		
Glades (%)	13	16
U.S.-born (%)*	45	30
Black, not Hispanic (%)*	40	23
Hispanic (%)^	53	67
Education		
HS grad (%)	24	23
Post-HS (%)	16	24
Teen mother (%)	18	19
Study risk index	3.60	3.77
Year 2 Characteristics		
Number of children		
One (%)^	44	30
Two (%)	32	42
Three or more (%)	24	29
Lives with husband or partner (%)^	65	78
Mother employed (%)	45	50
Income at or below poverty (%)	56	51
Target child special needs (%)	20	19
Other children special needs (%)	10	8
Mother has health problem (%)	6	6
Other household member has health problem (%)^	9	4
Number of housing problems*	1.17	1.74
Partner support score	9.18	10.63
Family/friend support score	8.59	8.43
Stress index ≥ 86 (%)	16	16
Depression ≥ 16 (%)	24	26
Negative parenting score**	.20	.48
Investigated DCF reports from birth to age 1 year (%)	10	4
Indicated DCF reports from birth to age 1 year (%)	6	3

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Table 90 presents the results of a logistic regression analysis of the likelihood of mothers having a negative parenting score above the 25th percentile.[77] The results show that virtually none of the variables that were significant in Table 69 remain significant after controlling for the effects of the other variables; the only variable that remains significant is the negative parenting

[77] Because the distribution of the negative parenting score departs significantly from normality, we conducted tests to determine whether any transformation of the score would result in a normal distribution. Failing to find such a distribution, we made the decision to conduct a logistic regression of the likelihood of a score in the upper 25th percentile instead of a linear regression on the raw score.

score in the previous year. Because of this finding, we also investigated the extent to which mothers' characteristics were associated with the negative parenting score in year 2. Results of bivariate analyses showed that, resembling the year 3 results, mothers with high scores in year 2 were significantly less likely to be U.S.-born, to be Black, to have only one child, and to live with a household member with a health problem; they also had higher negative parenting scores in year 1. Similarly, mothers with high scores in year 2 were more likely to be Hispanic and to be married or cohabiting. In addition, although teen mother status and friend/family support were not significant determinants of the year 3 scores, the results for year 2 indicated that mothers with higher negative parenting scores had significantly lower family/friend support scores in year 1 and were significantly less likely to have been teen mothers; the latter result might be a reflection of the fact that mothers with higher scores were more likely to be Hispanic, who were less likely than Blacks to have been teen mothers.

Table 90. Logistic Regression Analysis of Likelihood of Negative Parenting Score in Upper 25th Percentile in Year 3

Predictor Variable	Odds Ratio	Sig.
Number of services at year 3	0.91	*NS*
Glades	2.06	*NS*
Race/nativity		
Black—U.S.-born	0.51	*NS*
Black—foreign-born	0.41	*NS*
Hispanic—U.S.-born	0.40	*NS*
Hispanic—foreign-born (excluded category)	--	--
White/other	1.32	*NS*
Number of children (year 2):		
One	1.25	*NS*
Two	1.65	*NS*
Three (excluded category)	--	--
Lived with husband or partner (year 2)	1.13	*NS*
Other household member has health problem (year 2)	0.44	*NS*
Number of housing problems (year 2)	1.08	*NS*
Negative parenting score (year 2)	60.34	**
Constant	0.03	**
R^2	.28	

∧ $p \leq .10$, * $p < .05$, ** $p < .01$.

A logistic regression analysis of the year 2 score (not shown here) showed that the odds of having a negative parenting score above the 25th percentile were significantly lower ($p \leq .05$) for mothers with higher family/friend support scores, and for those living with a household member with a health problem. Also, at the 10-percent level, the odds of a high score were lower for mothers with only one child relative to those with three or more children. Overall, however, the variable with the greatest impact on the odds of a high score was the negative parenting score in year 1.

Children's Development

As discussed in Chapter 3, in the third-year interview mothers were asked about the age at which the focal child first achieved the following developmental milestones appropriate for 2-year-old children:

- Started walking up stairs alone
- Started saying words
- Started turning the pages of a picture book, one at a time
- Started opening the door by turning the knob and pulling
- Started playing with other children and doing things with them
- Started using an object as if it were something else (e.g., using a block for a phone, using a cardboard box for a car or a doll bed, using a napkin for a doll blanket)

In addition, to get a rough assessment of children's language development, mothers were asked how frequently the child combines words (not yet, once to several times a week, once a day, or several times a day) and to indicate which of the following statements best describes how the child communicates: (1) mostly talking in one-word sentences; (2) talking in two- to three-word phrases; (3) talking in fairly complete, short sentences; or (4) talking in long and complicated sentences.

Eighty-one percent of the children in the sample had reached all six milestones, 15 percent had reached five, and 3 percent had reached four; the remainder (less than 1%) had reached three. The mean number of milestones reached by the children was 5.8, with a standard deviation of 0.51. Also, 26 percent of the children were talking in either short or long sentences (the vast majority in short sentences), about half were talking in two- to three-word phrases, about a quarter were mostly talking in one-word sentences, and only 1 percent were not yet talking.

In this section, we use these measures to examine possible relationships between mothers' characteristics, including their use of services during year 3, and their children's development. Similarly to the analyses in the previous sections, we first compared the characteristics of mothers whose child did or did not meet the six developmental milestones listed above. We then conducted a regression analysis of the number of developmental milestones reached, employing as independent variables those factors that were significant in the bivariate analyses. We also compared the characteristics of mothers whose child was or was not speaking in either short or long sentences, and conducted a logistic regression analysis of the likelihood that the child was speaking in sentences.

Table 91 compares the characteristics of mothers whose focal child did or did not reach six developmental milestones. Interestingly, mothers of children who did not meet all six milestones reported using significantly more services ($p \leq .05$) during year 3. However, similar to the results for parental stress, this relationship may reflect the fact that mothers of children who did not reach the milestones may have had more needs than other mothers; it is also possible that the children themselves have more needs. Indeed, the results do indicate that children who

did not meet all milestones were significantly more likely to have been identified as having special needs. As a result, their mothers may have been more likely to have received special services related to their children's development, which may have in turn increased their overall service use.[78] Finally, this result may also be a reflection of the fact that mothers of children who did not reach all milestones were significantly more likely to be U.S.-born and Black, and, as discussed in Chapter 8, these mothers were found to use more services than foreign-born mothers.

Table 91. Characteristics of Mothers, by Child Developmental Milestones in Year 3

	Child Met Six Milestones	Child Met Less than Six Milestones
Number of services at year 3*	2.93	3.55
Baseline Characteristics		
Glades (%)	13	13
U.S.-born (%)*	41	53
Black, not Hispanic* (%)	40	27
Hispanic (%)	54	57
Education		
HS grad (%)	25	22
Post-HS (%)	17	19
Teen mother (%)	18	19
Study risk index	3.63	3.55
Year 2 Characteristics		
Number of children		
One (%)	41	45
Two (%)	33	36
Three or more (%)	26	19
Lives with husband or partner (%)	66	72
Mother employed (%)	46	42
Income at or below poverty (%)	54	55
Target child special needs* (%)	17	28
Other children special needs (%)	8	15
Mother has health problem (%)	5	7
Number of housing problems	1.21	1.38
Partner support score	9.36	9.74
Family/friend support score	8.48	8.80
Stress index ≥ 86 (%)	15	20
Depression ≥ 16 (%)	24	26
Negative parenting score^	.25	.19
Positive parenting score*	.75	.70
Investigated DCF reports from birth to age 1 year (%)	8	11
Indicated DCF reports from birth to age 1 year (%)	5	6

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

[78] Additional bivariate analyses showed that mothers whose children did not meet all milestones received more help in the area of child development, but the difference was not statistically significant.

The results also show that mothers whose child did not reach all of the milestones had significantly lower positive parenting scores. On the other hand, they also had lower negative parenting scores, although this difference was only significant at the 10-percent level.

Table 92 presents the results of a linear regression analysis of the number of developmental milestones reached by the focal child, using the explanatory variables that were found to be significant in Table 71. According to the results, the number of services mothers used in year 3 continues to be highly significant and negatively related to the number of milestones reached by the focal child. That is, the results indicate that the more services a mother used in year 3, the lower the number of milestones reached by her child. However, the size of the effect is relatively small; the coefficient indicates that an increase by one in the number of services used is associated with only a 0.05 reduction in the number of milestones reached. In other words, in order to experience a one-unit decline in the number of milestones reached, a mother would have to increase service use by 15. Also, the negative and significant effect of number of services may be a reflection of unmeasured needs on the part of the mother and/or child. In particular, although the indicator for the target child having special needs is negative and highly significant in the results, it is possible that there are other characteristics or needs of the children and/or their mothers that we have not captured.[79]

Table 92. Regression Analysis of Number of Developmental Milestones Reached by Child in Year 3

Predictor Variable	Coefficient	Sig.
Number of services at year 3	-0.05	**
Glades	-0.03	*NS*
Race/nativity		
Black—U.S.-born	0.06	*NS*
Black—foreign-born	0.16	^
Hispanic—U.S.-born	0.01	*NS*
Hispanic—foreign-born (excluded category)	--	--
White/other	-0.41	**
Target child—special needs (year 2)	-0.16	**
Negative parenting score (year 2)	0.18	^
Positive parenting score (year 2)	0.52	**
Constant	5.53	**
R^2	0.14	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

The results also show that the children of Black foreign-born mothers achieved more developmental milestones than children of Hispanic foreign-born mothers; however, the size of the difference is relatively small and is only significant at the 10-percent level. In addition, the children of mothers in the "other" racial/ethnic category achieved about half a developmental milestone less than children of Hispanic foreign-born mothers. However, the analysis does not shed light on possible reasons for these differences; there may be real racial/ethnic differences,

[79] In future analyses, when we have more than one year of developmental data on children, we will be able to use fixed effects regression methods to control for possible unmeasured characteristics of mothers and/or children.

or they might reflect differences in mothers' perceptions of their children's development. Finally, the children of mothers with higher positive parenting scores in year 2 achieved significantly more milestones. However, the size of the effect is relatively small, such that a one-standard deviation increase in the positive parenting score would increase the number of milestones reached by only about 0.09.

Table 93 compares the characteristics of mothers whose focal child was or was not speaking in sentences at the point of the year 3 survey. Of particular note are the characteristics associated with children's level of language development. That is, mothers who reported that their child was speaking in sentences used more services during the year preceding the year 3 interview; they also reported more support from friends and family and used more positive

Table 3. Characteristics of Mothers, by Child's Level of Language Development in Year 3

	Not Speaking in Sentences	Speaking in Sentences
Number of services at year 3*	2.91	3.44
Baseline Characteristics		
Glades (%)*	11	20
U.S.-born (%)*	36	62
Black, not Hispanic (%)*	32	54
Hispanic (%)*	61	38
Education		
HS grad (%)	22	28
Post-HS (%)	16	22
Teen mother (%)*	16	27
Study risk index	3.69	3.44
Year 2 Characteristics		
Number of children		
One (%)	42	42
Two (%)	33	37
Three or more (%)	26	21
Lives with husband or partner (%)*	71	56
Mother employed (%)	47	41
Income at or below poverty (%)	55	55
Mother has health problem (%)	5	6
Target child special needs (%)	18	25
Other children special needs (%)^	8	15
Number of housing problems	1.27	1.21
Partner support score	9.72	8.50
Family/friend support score*	8.25	9.55
Parenting stress index ≥ 86 (%)	17	15
CES-D depression ≥ 16 (%)	25	20
Negative parenting score	.25	.22
Positive parenting score*	.73	.77
Investigated DCF reports from birth to age 1 year (%)	9	12
Indicated DCF reports from birth to age 1 year (%)	5	7

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

parenting practices. They were also more likely to have been born in the United States and to be Black, and less likely to be Hispanic. Also, contrary to what might be expected, mothers whose children were speaking in sentences were more likely to have given birth as teenagers, less likely to be married or cohabiting, and more likely to be living in the Glades. However, these results may reflect the fact that mothers whose children were speaking in sentences were much more likely to have been born in the United States.

Table 94 presents the results of a logistic regression analysis of the likelihood that the focal child was speaking in sentences at the time of the year 3 survey. As in the bivariate analysis, number of services used in the year prior to the third interview continued to be positively related to the likelihood that the child was speaking in sentences, although only at the 10-percent significance level. In addition, as might be expected, mothers with higher positive parenting scores have significantly higher odds of having a child who was speaking in sentences, as do Black and Hispanic mothers born in the United States, relative to Hispanic foreign-born mothers. Finally, consistent with the bivariate analysis, the results continue to suggest that mothers who gave birth as teenagers were more likely to have a child who was speaking in sentences, even after controlling for race and nativity.

Table 94. Logistic Regression Analysis of Likelihood of Child Speaking in Sentences in Year 3

Predictor Variable	Odds Ratio	Sig.
Number of services (year 3)	1.14	^
Glades	1.10	*NS*
Race/nativity		
Black—U.S.-born	3.30	**
Black—foreign-born	1.68	*NS*
Hispanic—U.S.-born	2.87	*
Hispanic—foreign-born (excluded category)	--	--
White/other	2.73	^
Teen mother	1.86	*
Other child with special needs (year 2)	1.21	*NS*
Lived with husband or partner (year 2)	1.00	*NS*
Friend/family support score (year 2)	0.99	*NS*
Positive parenting score (year 2)	4.76	*
Constant	0.03	**
R^2	.16	

^ $p \leq .10$, * $p < .05$, ** $p < .01$.

Summary

A major objective of this chapter was to investigate whether mothers' service use, in the broadest sense, was related to their own or their children's outcomes. We found a small, positive relationship between the number of services mothers used in year 3 and their use of positive parenting practices. We also found a small, positive relationship between a mother's use of services and the likelihood that her child was speaking in sentences. Together, these results provide some support for the view that provision of support services to mothers of young children might lead to improvements in parenting and, ultimately, enhance child development.

In seeming contrast to these results, however, we also found a small, negative relationship between a mother's service use and the number of developmental milestones reached by her child. It should be emphasized, however, that the estimated coefficient indicated that a mother would have to increase service use by 16 in order to see an associated one-unit decline in the number of milestones reached by her child; thus, the indicated effect is quite small. Also, one explanation for the negative relationship between service use and developmental milestones is that the number of services used by mothers might be a reflection of unmeasured needs on the part of the mother, her child, or both, which are in turn related to the child's development. Future analyses with additional longitudinal data will allow us to say more about the relationship between these variables.

Finally, we found some notable and significant relationships between mothers' characteristics and selected maternal outcomes. First, we found that the odds of Black foreign-born mothers having depressive symptoms were almost 14 times as high as for Hispanic foreign-born mothers; we did not find any significant differences in the odds of depressive symptoms between U.S.-born Blacks and foreign-born Hispanics, or between U.S.-born Hispanics and foreign-born Hispanics. We also found that mothers who gave birth as teenagers and mothers who reported more housing-related problems were at higher risk of experiencing depressive symptoms.

We also found that Black foreign-born mothers had significantly greater odds of experiencing clinically significant parenting stress levels: specifically, the odds of such mothers having high stress levels were over five and a half times the odds for a Hispanic foreign-born mother. And, similar to the results for depressive symptoms, we did not find significant differences in the odds of parental stress for any of the other demographic groups of mothers (relative to Hispanic foreign-born mothers). In addition to race and nativity, we also found that having more children, and having a child with special needs, increased the odds of experiencing parental stress.

SUMMARY AND CONCLUSIONS

This is the third report of a longitudinal study examining the use of a comprehensive system of prevention and early intervention services in Palm Beach County and its effects on children and families living in four targeted geographic areas (TGAs). The TGAs were identified by the Children's Services Council (CSC) as having high rates of poverty, teen pregnancy, crime, and child abuse and neglect. By strengthening the services offered to families in these communities, CSC hopes to enhance parents' abilities to raise socially, emotionally, and physically healthy children who are eager to learn and ready for school. CSC's secondary goals are to increase the number of healthy births and to reduce the incidence of child abuse and neglect and teen pregnancy in these communities.

The primary goal of this study is to better understand families' patterns of service use over time and the impact of services on child and family outcomes. Although the focus of the study is the system of prevention and early intervention services funded by CSC, the study also collects data on the use of other services and community supports. Data sources included administrative records on Palm Beach County's 2004-2005 and 2006 TGA birth cohorts, survey data gathered from annual interviews with a baseline sample of 531 mothers drawn from the 2004 and 2005 TGA birth cohort, and qualitative data from interviews with a subgroup of 40 mothers randomly selected from the larger survey sample. This third report covers data from the first 3 years of the study. It presents findings for 390 mothers who were surveyed in all three years.

Summary of Year 3 Findings

Family Characteristics

As noted in previous study reports, compared with the 2004-2005 TGA birth cohort from which it was drawn, the study sample has a higher proportion of "risk" characteristics than mothers in the TGAs as a whole. This is to be expected given that mothers were recruited by staff of the two largest maternal child health programs, the Healthy Mothers/Healthy Babies Coalition and the Healthy Start program, which are most likely to have contact with mothers giving birth in the county. Thus, a majority (59%) of the study sample has less than a high school education, compared with a third (35%) of the TGA birth cohort. In addition, almost three-fourths (72%) of the study sample were unmarried at the time of the baseline interview, compared with 57 percent of the TGA birth cohort. In addition, the percentages of mothers in the study sample who were foreign-born, Black, and Hispanic were higher than the percentages in the TGA cohort.

In the third year of the study, as in the second year, a sizeable percentage (42%) of the study families reported that they had moved at least once during the preceding year. At the same time, most (90%) of them still lived in one of the TGAs. Twelve percent lived in the Glades TGA, 78 percent lived in the non-Glades TGAs, and 10 percent of the year 3 sample lived in other, nearby areas of Palm Beach County.

Nearly half (49%) of the mothers were working at the time of the year 3 interview, slightly more than the 45 percent working in year 2. (Overall, two-thirds of the mothers in the year 3 sample have worked at some point during the first 3 years of the study.) Mothers' estimates of their family income for the preceding year were very similar to those found in year 2, with half (50%) of the sample reporting household incomes of less than $20,000 for the previous year. Calculation of an income-to-need ratio based on household size, the number of children under age 18, and the federal poverty thresholds indicated that 54 percent of the families in the year 3 sample were living at or below the federal poverty threshold the previous year.

Household sizes remained fairly constant during the first 3 years of the study. The percentage of mothers who reported that they were married in the third year was the same as in the second year (30%), although the percentage of unmarried mothers who were living with a partner (33%) continued to decline from the first (40%) and second (37%) years. At the same time, there was an increase in the percentage of mothers with two or more children; two-thirds of the sample had two or more children at the time of the third interview. Almost one-quarter (24%) of the mothers had had another child since the birth of the focal child, and 8 percent were pregnant at the time of the year 3 interview.

Health, Maternal Functioning, and Child Development

Mothers in year 3 showed improvements on three indicators of maternal functioning—self-reported health, a measure of depression, and a measure of parental stress. Most (85%) of the mothers described themselves as in "good" to "excellent" physical health in year 3 compared with 78 percent in year 2. Smaller percentages of mothers than in previous years had above-normal scores on the CES-D depression scale (19%) and the PSI/SF measure of parenting stress (11%). In terms of the percentage of mothers with reports of abuse or neglect in the DCF database, however, there was a small increase from year 1 to year 2. Almost 10 percent of the mothers in the year 3 sample were investigated in the first year of their child's life, and 5 percent had indicated reports; almost 11 percent were investigated in the second year, and 7 percent had indicated reports.

Another study indicator of maternal health is access to health care. A majority (73%) of the mothers reported receiving regular medical care for themselves at the time of the year 3 interview. However, this means that more than a quarter of the sample mothers were going without routine health care and are, moreover, less likely to have access to services to keep them healthy between pregnancies and healthier should they become pregnant again. In that regard, use of prenatal care by mothers who had given birth to another child subsequent to the focal child followed the same pattern observed with the focal child. That is, among the 24 percent of the mothers who had had a subsequent pregnancy, about two-thirds (68%) said they had initiated care in the first trimester, 24 percent in the second trimester, and 6 percent in the third trimester.

Another result that raises concern was the fact that only 39 percent of the year 3 sample mothers reported having health insurance for themselves, also a slight decline from the previous year. In terms of both health care and health insurance, there were marked differences between immigrant and native-born mothers. Native-born mothers were more likely to receive regular

care (82%) than foreign-born mothers (66%), and only 15 percent of foreign-born mothers had health insurance in the third year compared with 71 percent of native-born mothers.

The results for children's health and development were more encouraging. Based on mothers' reports on a small number of measures used in the national ECLS-B longitudinal study of children's physical, cognitive, social, and language development, most of the children were developing within ranges comparable to the national sample. Most mothers also reported the focal child to be in "good" to "excellent" physical health, although 18 percent said that the focal child had "special needs," with asthma and other respiratory problems the dominant types of special needs.

Parenting Practices

Mothers were asked to report on a variety of parenting practices for them and their husbands or partners during the 3 months prior to the third-year survey. More than three-quarters of the mothers reported that they engaged in a variety of positive parenting activities, such as taking their child on errands, praising their child, taking their child outside to play, singing songs and reading books with their child, and doing art activities with their child. For families in which husbands or partners had contact with their children, mothers reported that about two-thirds or more of fathers engaged in most positive parenting activities. Smaller percentages of mothers reported that they or their husband/partner used negative parenting practices, such as losing their temper with their child (53%), hitting or spanking their child (31%), and getting angrier with their child than they had intended (22%) during the previous 3 months. Mothers whose husbands or partners had had contact with their children reported somewhat lower percentages of negative parenting practices for their husband or partner than they reported for themselves.

Over time, positive parenting activities increased for both mothers and fathers, but most of the changes occurred between the first and second year. There were no significant changes in the overall mean negative parenting scores for mothers and their husbands/partners over time, although there were some changes in selected practices by both mothers and fathers. There was a decrease between year 1 and year 2 of reports of getting angrier than intended with a child and punishing a child for not finishing food, but an increase between year 1 and year 2 of reports of hitting or spanking children.

We also found associations between parenting practices and a number of family characteristics, including educational background, race/ethnicity, and immigrant status, although it is important to keep in mind that many of these characteristics are highly correlated. Other significant associations suggest that maternal employment, marital status, and cohabitation may also influence mothers' parenting practices. The qualitative data provided additional insights on the factors that influence parenting, including mothers' underlying beliefs and values. We found that a dominant theme underlying the organization of the daily lives and decision making of all of the study families was mothers' overarching commitment to the well-being of their children. This factor stood out among other important influences, such as the stability of food, work, income, and childcare on the decisions mothers make to sustain their families.

Use of Childcare

More than half (53%) of the mothers in the third year of the study were using nonparental care arrangements for the focal child, motivated largely by their need for childcare as they returned to work. Although maternal employment was the most significant factor affecting use of child care, mothers' race/ethnicity and immigrant status also affected childcare use. Mothers who identified themselves as Black—both foreign-born and U.S.-born mothers—were much more likely to use childcare than foreign-born Hispanics. Although Hispanic mothers born in the United States were somewhat more likely to use childcare than foreign-born Hispanic mothers, these differences were not statistically significant in a regression analysis.

The most frequently reported type of nonparental arrangement for the focal children was center care, followed by relative care, and care by a friend or neighbor. When mothers were able to exercise some choice in their childcare arrangements, they were influenced by many factors, including the cost of care relative to their economic resources, information about and availability of childcare, and location and access to transportation. They also were influenced by their beliefs and values about using formal childcare and the quality of care they desired for their children. Some mothers, especially native-born mothers and foreign-born mothers who had lived in the United States for a number of years, seemed to be more comfortable with the idea of nonparental childcare by the third year of the study than they had been in previous years. Their choices were affected by their children's increasing independence and verbal skills, the greater availability of center programs (e.g., Head Start and preschool) for 3- and 4-year-old children, and their belief that some kinds of childcare will benefit their children socially and educationally.

Bivariate analyses suggest that different types of childcare arrangements are associated with a number of maternal characteristics, including race/ethnicity, nativity, education, employment, and income. Among Black mothers, a third (33%) used center care, and 31 percent had a relative who took care of their children. Among Hispanic mothers, a third (34%) relied on a friend or neighbor to care for their children, and one-fourth (25%) used relative care. Foreign-born mothers were much more likely to use care by friends or neighbors than U.S.-born mothers, whereas U.S.-born mothers were more likely to use center care and then relative care.

There were no differences in the use of center care by nativity, however; about a third of both native-born and foreign-born mothers used center care. This result is a change from the previous year when native mothers were much more likely to use center care than foreign-born mothers. The qualitative data along with the survey data suggest that their own needs and preferences influence mothers' choices in childcare arrangements, but cost remains an important factor; for example, most of the mothers using a center-based program for their child were part of the childcare subsidy system. Mothers who received a subsidy were much more likely to have their child in a childcare center, Head Start, or pre-kindergarten program (75%) than mothers who did not receive a subsidy (17%). More than two-thirds (69%) of mothers not using a subsidy paid friends or relatives to care for their children, compared with 8 percent of mothers who received a subsidy.

Social Support

Mothers in the third year continued to voice high satisfaction with the level of informal support they receive. As in previous years, if mothers have husbands or partners, they most often received support from them, although the mean level of support from husbands and partners was lower in year 3 compared with year 2. Otherwise, mothers relied primarily on their family, especially siblings and mothers or stepmothers. In addition to family members, mothers depended on friends for support, although less than half of the sample reported receiving support from a friend. The mean support score based on mothers' reports of help received from family and friends in the third year was similar to that in the second year; on average, both scores were lower than the mean support score for the first year. In addition, except in the area of child discipline, we also saw a decline in the frequency with which different kinds of support were provided by husbands or partners, other family members, and friends.

In contrast to the first two years, more than half of the mothers reported receiving support from one or more individuals in the community, either advice on children or household problems or help with money, food, or clothing. There was an increase from year 2 (15%) to year 3 (29%) in the percentage of mothers who cited doctors as a form of community support. There was also an increase in the percentage of mothers reporting support from their child's teacher. As in the previous year, almost one-fifth (18%) of mothers said they received support from a place of worship.

Survey data showed that mothers' perceptions of their access to social support, regardless of source, fluctuated over time. The qualitative data suggested a variety of reasons for these changes over time. Sometimes relatives are no longer able to help with childcare or turn out to be unreliable caregivers, so mothers have to find other sources of help. Over time, as their children grow older and if they can afford it, mothers living with relatives or friends increasingly desire more independence and try to set up households of their own—although they may continue to share resources such as childcare and food stamps. They also express more confidence in their parenting abilities and, although respondents' mothers remain an important source of information and support, respondents appear to be turning more to doctors, teachers, and other non-family for information and support than in previous years.

Service Use

Information on service use came from both mothers' self-reports and the FOCiS administrative data on service use in the Healthy Beginnings system. The administrative data indicated that among mothers in the 2004-2005 TGA birth cohort, less than half (40%) received services from Healthy Beginnings. Consistent with the population targeted by the Healthy Beginnings system, mothers who were teens, were unmarried, had less than a high school education, were Hispanic, or were foreign-born were more likely to receive services. Twice as many mothers in the year 3 study sample (80%) received services from Healthy Beginnings providers. Most of these services were provided during the 3 months before and 6 months after the birth of a child.

In terms of other service use, in year 3 a majority of mothers continued to receive help with health care for themselves and their families, and food assistance. Across the three years, about the same proportion of mothers—20 to 25 percent—received help with dental care, and

about a third received help with family planning in years 2 and 3. Furthermore, compared with year 1, there was a small increase in the proportion of mothers getting help with childcare in year 3.

Although a majority of mothers continued to receive food assistance in year 3, and those who received this assistance were those who were more likely to need it, there was a significant decline in this area of help between years 1 and 2 and year 3. There was also a significant decline between years 1 and 2, and between years 2 and 3, in the proportion of mothers who received help with parenting information. Comparisons of the characteristics of mothers who continued receiving parenting information with those who did not revealed little in the way of significant differences in mother characteristics. However, survey data on social support and additional qualitative interview data suggest that one reason for the decline is that mothers increasingly turned to other sources, including books and magazines and pediatricians and teachers for parenting information.

With respect to the overall number of areas in which mothers received help the third year, 15 percent of mothers received help in five or more areas; about a third received help in three or four areas; half received help in just one or two areas; and 4 percent did not receive help in any areas. Bivariate analyses suggested that mothers who used five or more services were more likely to be U.S.-born, be Black, have a child with special medical needs, have incomes at or below poverty, have three or more children, have one or more investigated DCF reports, and have received intensive care coordination services through the Healthy Beginnings system. A subsequent regression analysis showed that U.S.-born Blacks used about one more service on average than foreign-born Hispanics, whereas foreign-born Blacks used about half a service less. Also, mothers with three children were found to use about one service more when compared with mothers with only one child. In addition, employed mothers and those with two children used about half a service less relative to their respective comparison groups, and mothers who had a child with special needs used half a service more.

Between years 1 and 3, a little more than 10 percent of mothers increased their use of services by two or more, while almost 30 percent reduced their use of services by two or more. Bivariate analyses showed that mothers who decreased their use of services were more likely than those with little or no change in service use to be U.S.-born, be Black, live with a household member with a health problem, and have a high depression score. Thus, there is some evidence that mothers with more needs were more likely to experience a reduction in service use. There were also some substantive differences between mothers who increased their service use and those with little or no change; however, due partly to the small size of the former group, the differences were not found to be statistically significant. Finally, a regression analysis indicated that mothers with fewer children were less likely to increase their use of services, but the same was true of mothers living with a household member with a health problem. In addition, the analysis suggested that U.S.-born Blacks were more likely to increase their use of services relative to foreign-born Hispanics. Lastly, we found that mothers who experienced a major life change between years 1 and 2 tended to use more services in year 3; there were statistically significant differences in service use for mothers who gave birth, moved two or more times, lost employment, or had a child with special needs.

Overall, the data indicate that mothers with greater needs received more help, and that mothers whose circumstances changed for the worse also received more help. The exception to this conclusion is the finding that mothers living with a household member with a health problem were less likely to increase their use of services. Also, the results overall suggested that, all else being equal, foreign-born mothers—both Black and Hispanic—were less likely to receive help. Based on the qualitative data, it appears that foreign-born mothers were less likely to seek help but also may have been less likely to receive help when they sought it. Immigrant families, for example, were more likely to have difficulty with childcare, transportation, language, and literacy issues than native-born families. It also was more difficult for them to get to appointments to apply for or receive services, which typically required their husband or partner to take time off from work and lose a day of wages. Language barriers also kept immigrant families from acquiring accurate information about their eligibility for services.

Service Use, Maternal Functioning, and Child Development

The PBC longitudinal study provides a unique opportunity to understand the potential consequences of mothers' use of services, in the broadest sense, for their families' well-being and children's development. This year we examined how mothers' overall service use is related to their own and their children's outcomes. We examined the maternal outcomes of depression, parental stress, and positive and negative parenting practices. For the focal children, we looked at the number of developmental milestones reached by the third interview and their level of language development.

We found a small, positive relationship between the number of services mothers used in year 3 and their use of positive parenting practices. We also found a small, positive relationship between a mother's use of services and the likelihood that her child was speaking in sentences. Together, these results provide some support for the view that provision of support services to mothers of young children might lead to improvements in parenting and, ultimately, enhance child development. On the other hand, we also found a small, negative relationship between service use and the number of developmental milestones reached by the focal child. One explanation for the negative relationship between service use and developmental milestones is that the number of services used by mothers might reflect unmeasured needs on the part of the mother, her child, or both, which are in turn related to the child's development. Future analyses with additional longitudinal data will allow us to say more about the relationship between these variables.

Finally, we found some notable relationships between mothers' ethnic characteristics and selected maternal outcomes. First, the odds of Black foreign-born mothers having depressive symptoms were almost 14 times as high as those for Hispanic foreign-born mothers; we did not find any significant differences in the odds of depressive symptoms between U.S.-born Blacks and foreign-born Hispanics, or between U.S.-born Hispanics and foreign-born Hispanics. We also found that mothers who gave birth as teenagers and mothers who reported more housing-related problems were at higher risk of experiencing depressive symptoms. Black foreign-born mothers also had significantly greater odds of experiencing clinically significant parenting stress levels; the odds of such mothers having high stress levels were over five and a half times the odds for a Hispanic foreign-born mother. And, similar to the results for depressive symptoms,

we did not find significant differences in the odds of parental stress for any of the other demographic groups of mothers (relative to Hispanic foreign-born mothers). In addition to race and nativity, we also found that having more children and having a child with special needs increased the odds of experiencing parental stress.

Given the potential relationship between maternal functioning and parenting practices, it appears that services to address depression and parenting stress are an important component of the prevention and early intervention service system. They also indicate that the provision of services may require different approaches for different ethnic groups. The qualitative data suggest that a primary motivation to use services is mothers' commitment to their role as parents and to ensuring their children's well-being. Although mothers have personal goals (e.g., to go back to school, get a better job, learn a new language, and achieve financial stability) and they would prefer to be independent and not rely on formal services, there are innumerable obstacles mothers need to overcome in order to pursue their goals. Yet many mothers are willing to put in the personal effort needed to address the individual-level barriers, such as transportation, language issues, and conflicting information about service requirements, to use the services available to them if it means improving the welfare of their children.

Study Limitations

It should be noted that one limitation of the current study is the reliance on mothers' self-reports on service use and service records, both of which may contain inaccuracies. On the other hand, in time these data sources will be integrated with other data, including qualitative interviews and other administrative records; these multiple data sources provide a more complete and credible picture of service use and effects. Another limitation to note is that this study is nonexperimental (i.e., families are not randomly assigned to services) and cannot definitively attribute differences in family and child outcomes to services, although its comprehensive and longitudinal design will allow us to describe and suggest explanations for relations between family characteristics, service use, and outcomes. In addition, although the study's sample is a heterogeneous, low-income sample of families, it is important to note that our findings may not generalize to other low-income families outside the targeted communities that are the focus here.

At the same time, this study is providing a wide-ranging look at service use (and service non-use) in a diverse group of low-income families, including publicly funded health care and income supplements as well as a network of smaller, voluntary prevention and early intervention services. It also is providing extensive information about other factors that may affect family functioning and children's development. The findings are strengthened by the use of multiple data sources and mixed methods, involving the ability to link individual-level administrative data across service systems and the opportunity to look in depth at the service experiences of a small sample of the study families. This study also highlights the importance of looking at the effects of service use in a broader ecological context that includes the multiple service systems that low-income families are likely to have to navigate.

Conclusions and Implications

By concentrating services in the four areas of Palm Beach County with the highest rates of poverty, teen pregnancy, crime, and child abuse and neglect, CSC intends to assist families whose children are most vulnerable to starting school behind their peers. Underlying CSC's efforts is the assumption that a strong system of community supports and prevention services in the TGAs will result in healthier families, children who are better prepared for school, and fewer families needing more intensive mental health, child welfare, and juvenile justice services. In order to obtain the benefits that services might provide, though, families must use them. A critical challenge for voluntary prevention and early intervention programs, in particular, is engaging potential clients in services long enough to obtain the benefits that high-quality services can provide. Thus, the focus of the longitudinal study is to understand what services families in the targeted communities are using, how the services they use help them care for their children, and the impact of these services on children's outcomes.

Given that the demographic characteristics of families living in the TGAs are the ones associated with children's poor outcomes for school readiness and performance, CSC's strategy of targeting its services to families in the TGAs appears to be a sound one for reaching children who are most at risk of not succeeding in school. However, the study's findings in the third year suggest that some services may not be reaching many families in the TGAs who might benefit from them. Although a large percentage of the study families used available food and health care services in the early years of their children's lives, the percentages using other kinds of services were much smaller.

For example, administrative records show that a large majority (80%) of the year 3 sample had contact with the Healthy Beginnings system around the birth of the focal child, but only about a quarter were still receiving services 6 months after birth. In addition, although half of the mothers in the sample used some form of childcare arrangement, only about a third (32%) were using either center-based programs or family childcare that might be touched by CSC's early education and childcare quality initiatives or the Comprehensive Services program's screening and referral services. Although families' use of center care may increase as their children get older, differences are likely to persist both because of the lack of affordable quality childcare and childcare subsidies as well as the individual preferences of families for different types of care.

These findings suggest there are opportunities to improve service access and use in the TGAs. At the same time, the challenges are many. Given the variability in family circumstances, services that have more flexibility to adapt to the circumstances of the low-income families they are intended to serve may be more likely to reach these families. In other words, services will be most beneficial if they are designed to fit into, and add to the stability of, families' daily lives. Families are less likely to use services, such as childcare, that do not fit well with their daily routines, are not easy to get to with available transportation or do not fit with their work hours, or that conflict with their values. Thus, the year 3 findings imply several challenges and opportunities for improving access to and use of CSC's prevention and early intervention services, as described below:

- **Keeping families involved in services over time**
  In this study, more mothers decreased their service use than increased it. We saw declines in use of food assistance and a continuation of the decline in use of formal parenting information. This decline may be the result of individual factors, such as mothers not perceiving a need for these services, perhaps because they feel more confident in their parenting skills or because they increasingly turn to pediatricians and teachers for parenting information, or, on the other hand, because they have more pressing concerns, such as food and health care. But given that each new developmental stage brings with it its own challenges for parents, it also may reflect the lack of connections to home-based services for parents of older children (e.g., the Parents as Teachers and HIPPY programs) once they leave the Healthy Beginnings system. Our analysis of the administrative data suggests that less than 20 percent of mothers in the year 3 sample were still receiving intensive care coordination services after the focal child's first birthday. Although mothers may receive referrals to additional services within or outside the system, it is not clear if they actually are connected to these services.

  In this regard, both the quantitative and qualitative data for this report indicate the potential importance of social workers for connecting mothers to economic support and other services. Although these providers often were a direct source of other services—e.g., parenting advice or mental health services—they also were an essential bridge or "broker" between some mothers and basic services, including Medicaid, food assistance, and childcare subsidies. A number of mothers talked about contacting social workers in the hospital where they gave birth or at another agency for assistance in reapplying for public services. This finding of the potential importance of social workers for connecting mothers to economic support and other services suggests that expansion of case management services for mothers who are not necessarily "at risk" but who need assistance in maintaining their services might be warranted. This might be a service that CSC could continue to fund after the initial postnatal period to increase the stability of family life and service use.

  Another strategy for keeping families engaged in services is to improve the responsiveness of service providers. The qualitative data indicate that CSC's investments in training for service providers in culturally appropriate and family-strengths-based approaches are warranted. At the same time, it has to be recognized that CSC may not be able to directly impact providers of services in federal programs or other agencies not funded by CSC, although raising public awareness of the literacy and educational needs of families, in addition to their service needs, in the targeted communities might help. Families can be intimidated by the program concepts and requirements, and staff who are trained to help families through the process could reduce future duplication of paperwork as well as client and staff frustration. Over time, investing in changing staff behaviors to better serve disfranchised families with young children may boost families' self-respect, make them feel more positive about seeking and accepting help, and prove cost-effective in terms of their future service needs.

- **Making location and timing of services convenient for families**
  Of the many factors that constrain service use, the locations of program offices, their hours, and waiting times are often inconvenient for families, especially if they have transportation or childcare problems. Strategies that CSC-funded programs use, such as home visits and

traveling service vans, are good alternatives to office visits, especially if they are available during evening and weekend hours. Basing services at schools, Beacon Centers, or childcare centers is another option for reaching families who have children enrolled in school or formal childcare. As it may be difficult to persuade employers to allow families time off for appointments with teachers, doctors, or service agencies without jeopardizing their wages, it may be more feasible to persuade health care providers, schools, and service agencies to provide services at times that are convenient for families.

- **Providing continuity of services during periods of instability**
  Economic support and childcare subsidy programs with strict income thresholds or work requirements can be problematic for low-income working parents, whose sources of income may be irregular. Programs and policies that recognize the changing circumstances of low-income families and try to add to the stability of families' lives are more likely to impact a larger number of families. One example is CSC's Continue-to-Care Initiative, which provides transitional support when changes in mothers' education or employment status might jeopardize their eligibility for childcare subsidies and result in disruptions of children's care arrangements. Similar programs in the areas of health care and food may also benefit families.

- **Improving channels of communication for service information**
  There may be other vehicles (such as radio, television, faith-based organizations, and public libraries) for disseminating information that will reach families with limited education or literacy skills, families who do not receive information through family or friends, and families who are not already using other services.[80] The local offices of federal benefit programs are also channels for disseminating information about CSC-funded programs; for example, one of the study mothers was referred by a nurse in the WIC office to a provider in the Healthy Beginnings system.

- **Strengthening relationships with community organizations and other service systems**
  CSC's strategies to enhance children's school readiness by improving the quality of childcare and providing referrals through the Comprehensive Services program could benefit families who use formal childcare services, either center-based programs or family childcare. However, this approach obviously will not reach the many mothers who are not working, who are either not eligible or on a waiting list for a childcare subsidy, or who prefer to use other childcare settings. Other strategies are needed to reach these families, for example, through other service providers, such as WIC and community outreach. Family empowerment programs also can be an effective source of information about services, support, and advocacy and may be most effective when they partner with the programs most families already use, such as WIC, public health clinics, and Medicaid.

  Most mothers in the study sample told us that they get what they perceive as an adequate level of support from family members, but there is also evidence that these informal support networks can be fragile and may not always add stability to their lives. On the other hand, there was an increase in reported levels of community support, especially by medical

[80] CSC has recently started making more use of the media to provide information about childcare and other parent education.

personnel, in the third year. Strengthening connections with pediatricians and nurses and informing them about available parenting services might be another way to increase families' awareness and knowledge of these services.

- **Engaging harder-to-reach families**
  Some segments of CSC's target population may be harder to reach and engage in services. Immigrant families, especially those with undocumented members, pose a particular challenge for service delivery. Although the adults in these families may be ineligible for some programs, their children who are U.S. citizens are eligible for services, such as food stamps, health insurance, and health care. More effort could be given to informing these families of their children's rights to services and the potential benefit to their children of using them. Addressing immigrant families' concerns about using services by providing accurate information about programs and helping families with the language, literacy, technical, or other knowledge needed to navigate the application process is also needed. Besides reaching these families through the services they do use, this implies partnering with agencies that work specifically with immigrant populations and identifying other resources in immigrant communities through which to reach these families. Mobile service units may be another way to reach families in more isolated communities with parenting, literacy, and health services.

- **Improving sources of information on service availability, use, and need**
  The FOCiS database is an important source of information on the types of services families receive in the Healthy Beginnings system and the kinds of referrals made to providers outside the system. There may be more analyses we can do with the data currently available to understand how families enter and leave the system as their families grow. At the same time, additional sources of information on the location of services, community needs for services, and the outcomes of referrals would assist funders and providers of services for planning purposes.

In conclusion, the third-year results indicate wide variability in service use among families in the TGAs. Just a small proportion (15%) of the study families received services in five areas or more in the third year. Their high service use was associated with being native-born, being Black, having more children, and having a child with special medical needs. They were also more likely to have received intensive care coordination services through the Healthy Beginnings system. This means that they had contact with a care coordinator, nurse, social worker, or another professional for a longer period of time, which likely facilitated their participation in services. Families with greater needs are more likely to use services, but it is also true that immigrant families are less likely to receive services than native-born families.

The variations in service use over time also imply the importance of analyzing data on service use longitudinally rather than at only one point in time. To be effective, program policies and practices need to be grounded in the circumstances of the low-income families they are intended to serve and take into account the range of different services and systems with which they may have contact. As we continue to learn more in the course of this study about families and services in the TGAs—including the reasons for service disparities, the needs of families, their sources of information about services, their service experiences, and the other factors that

affect family functioning and children's development—we will learn more about how to strengthen community supports and design effective and flexible services and service delivery to fit the diverse needs and circumstances of these families.

We also will continue to investigate the relationship between receipt of maternal and child health services and the use of other services (e.g., health care, food assistance, family planning, childcare, and social services), maternal outcomes, and child development with survey and administrative data over time. Qualitative data on mothers' service experiences will provide additional perspectives on the barriers and facilitators—including characteristics of families, communities, providers, and programs—that affect mothers' decisions to use services and ongoing participation in services. We will investigate the role these various, overlapping factors play in service use, vary from one service area to another, and change over time as family circumstances change.

Bibliography

Abidin, R.R. (1995). *Parenting Stress Index, 3rd edition*. Lutz, FL: Psychological Assessment Resources, Inc.

Aday, L.A. & Andersen, R.M. (1975). *Development of indices of access to medical care*. Ann Harbor (MI). Health Administration Press.

Andersen, R.M. (1995). Revisiting the behavioral model and access to medical care: Does it matter?. *Journal of Health and Social Behavior*, *36* (1), 1-10

Andreassen, C., and Fletcher, P. (2007). *Early childhood longitudinal study, birth cohort (ECLS–B) psychometric report for the 2-year data collection* (NCES 2007–084). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education. Washington, DC. Retrieved June 12, 2008, from http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2007084

Attree, P. (2005). Parenting support in the context of poverty: A meta-synthesis of the qualitative evidence. *Health and Social Care in the Community*, *13*, 330-337.

Bernheimer, L. (1994). Ecocultural assessment in families of children with developmental delays. *American Journal on Mental Retardation*, *98*, 551-566.

Bradley, R. & Caldwell, B. (1988). Using the home inventory to assess the family environment. *Pediatric Nursing*, *14*, 97-102.

Bradley, R.H. & Corwyn, R.F. (2002). Socioeconomic status and child development. *Annual Review of Psychology*, *53*, 371-399.

Bronfenbrenner, U. (1986). Ecology of the family as context for human development: Research perspectives. *Developmental Psychology*, *22*, 723-742.

Brooks-Gunn, J. (2003). Do you believe in magic?: What we can expect from early childhood intervention programs. *Social Policy Report, 17*(1), 3-14.

Brooks-Gunn, J., Duncan, G., Klebanov, P.M., & Sealand, N. (1993). Do neighborhoods influence child and adolescent development?, *American Journal of Sociology, 99* (2), 353-395

Brooks-Gunn, J., Duncan, G.J. & Aber, J.L (Eds.). (1997). *Neighborhood poverty: Context and consequences for children* (vol.1). New York: Russell Sage Foundation.

Chase, R., Arnold, J., Schauben, L., & Shardlow, B. (2005). *Childcare use in Minnesota: 2004 statewide household childcare survey.* St. Paul, MN: Wilder Research.

Chaudry, A. (2004). *Putting children first*. New York: Russell Sage Foundation.

Children's Service Council. (2008). *State of the child in Palm Beach County: Early care and education - school readiness update*. Retrieved July 16, 2008, from http://cache.trustedpartner.com/docs/library/000238/ECESchool_Readiness2008.pdf

Children's Service Council (2006). *Infant and Toddler Needs Assessment of Palm Beach County.* Unpublished manuscript, West Palm Beach, FL: Children's Services Council.

Covering Kids and Families. (2005). *One in 4 Uninsured children in Florida had no medical care for the entire year*. Retrieved May 14, 2008, from ww.coveringkidsandfamilies.org.

Daro, D., Huang, L. A., & English, B. (2008). The Duke Endowment Child Abuse Prevention Initiative: Mid-Point Assessment. Chicago, IL: Chapin Hall.

Daro, D., McCurdy, K., Falconnier, L., & Stojanovic, D. (2003). Sustaining new parents in home visitation services: Key participant and program factors. *Child Abuse & Neglect, 27*, 1101–1125.

Dinan, K. A. (2005a). *Federal polices restrict immigrant children's access to key public benefits: Children in low-income immigrant families policy brief.* National Center for Children in Poverty. Retrieved June 5, 2008, from www.nccp.org/pub_fpr05.html.

Dinan, K. A. (2005b). *State policies can promote immigrant children's economic security: Children in low-income immigrant families policy brief.* National Center for Children in Poverty. Retrieved June 5, 2008, from www.nccp.org/pub_spc05.html.

Duncan G.J. & Brooks-Gunn, J. (2000). Family poverty, welfare reform, and child development. *Child Development*, *71,* 188-196.

Ecocultural Scale Project (1997). *The ecocultural family interview manual*. Unpublished manuscript, Los Angeles, CA: Ecocultural Scale Project.

Edin, K. & Lein, L. (1997). *Making ends meet: How single mothers survive welfare and low-wage work.* New York: Russell Sage Foundation.

Elder, G. H., Eccles, J.S., Ardelt, M., & Lord, S. (1995). Inner-city parents under economic pressure: Perspectives on the strategies of parenting. *Journal of Marriage and the Family, 57*, 771- 784.

Elder, G.H., Conger, R.D., Foster, E.M., & Ardelt, M. (1992). Families under economic pressure. *Journal of Family Issues 13*, (1), 5-37

Epstein, J.L. (2001). *School, family, and community partnerships*. Boulder, CO: Westview Press.

Federal Interagency Forum on Child and Family Statistics. (2008). *America's children in brief: Key national indicators of well-being.* Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government. Printing Office. Retrieved July 18, 2008, from http://www.childstats.gov/americaschildren/phenviro.asp

Fleischman, L. (2004). *Family and Community Partnership: Implementation evaluation 2002-2003*. West Palm Beach, FL: The Children's Services Council of Palm Beach County.

Fuller, B., Holloway, S.D., & Liang, X. (1996). Family selection of childcare centers: The influence of household support, ethnicity, and parental practices. *Child Development, 67*, 3320-3337.

Gennetian, L., Duncan, G., Knox, V., Vargas, W., Clark-Kauffman, E., & London, A. (2002). *How welfare and work policies for parents affect adolescents: A synthesis of evidence from random assignment studies*. New York: MDRC.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York. Aldine.

Goerge, R.M., Reidy, M., Lyons, S., Chin, M., & Harris, A. (2004). *Understanding the food stamp program participation decisions of TANF leavers.* Chicago, IL: Chapin Hall Center for Children.

Gomby, D.S. (2005). Home visitation in 2005: Outcomes for children and parents. Committee for Economic Development: Invest in Kids Working Paper No. 7. Retrieved June 13, 2008, from www.ced.org.

Harris, J., Pryor, J., & Adams, S. (1997). The challenge of intercoder agreement in qualitative inquiry. Unpublished manuscript, University of Texas at Austin. Retrieved January 20, 2006, from http://emissary.wm.edu/templates/content/publications/intercoder-agreement.pdf.

Henly, J. R. & Lyons, S. (2000). The negotiation of childcare and employment demands among low-income parents. *Journal of Social Issues, 56 (4),* 683-706.

Henly, J.R., Danziger, S.K. & Offer, S. (2005). The contribution of social support to the material well-being of low-income families. *Journal of Marriage and the Family*, 67, 122-140.

Hernandez, D., Denton, N., & Macartney, S. (2007). *Children in immigrant families - the U.S. and 50 states: national origins, language, and early education*. Albany, NY: University at Albany: Child Trends and The Center for Social and Demographic Analysis. Retrieved May 16, 2008, from http://www.childtrends.org/Files/Child_Trends-2007_04_01_RB_ChildrenImmigrant.pdf

Hill, N.E. & Craft, S.A. (2003). Parent-school involvement and school performance: Mediated pathways among socioeconomically comparable African American and Euro-American Families. *Journal of Educational Psychology, 95*, 74-83.

Jackson, A., Gyamfi, P., Brooks-Gunn, J., & Blake, M. (1998). Employment status, psychological well-being, social support, and physical discipline practices of single black mothers. *Journal of Marriage and Family, 60*, 894-902.

Jang, Y., Kim, G., & Chiriboga, A.D. (2005). Health, health care utilization, and satisfaction with services: Barriers and facilitators for older Korean American. *Journal American Geriatric Society, 53*, 1613-1617

Jeynes, W.H. (2003). A meta-analysis: The effects of parental involvement on minority children's academic achievement. *Education and Urban Society, 35 (2*), 202-218.

Kinukawa, A., Guzman, L. & Lippman, L.(2004). *National estimates of childcare and subsidy receipt for children ages 0 to 6: What can we learn from the national household education survey?*. Washington, DC: Child Trends. Retrieved July 27, 2007, from http://www.childtrends.org/Files/NHES_Research_brief_10_19_04.pdf.

Kissane, R.J. (2003). What's need got to do with it? Barriers to use of nonprofit social services. *Journal of Sociology and Social Welfare*. *30* (2), 127-148

Leventhal. T., Brooks-Gunn, J., McCormick, MC, & McCarton, C. (2000). Patterns of service use in preschool children: Correlates, consequences, and the role of intervention. *Child Development, 71*(3), 802-819

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lippman, L., Vandivere, S.,Keith, J. & Atienza, A. (2008). *Childcare use by low-income families: Variations across states*. Washington, DC: Child Trends. Retrieved July 2, 2008, from http://www.childtrends.org/Files//Child_Trends-2008_07_02_RB_ChildCareLowIncome.pdf.

Lowe, E.D. & Weisner, T. (2004). 'You have to push it'- who's going to raise your kids?: situating childcare and childcare subsidy use in the daily routines of lower income families. *Children and Youth Services Review, 26*, 143-171

Lyons, S. & Winje, C. (2006). *Helping families shine: Evaluation of the Family and Community Partnership, Palm Beach County, Florida*. Chicago: Chapin Hall Center for Children.

Lyons, S., Henly, J., & Schuerman, J. (2005). Informal support in maltreating families: Its effect on parenting practices. *Children and Youth Services Review, 27*, 21-38.

McCurdy, K. & Daro, D. (2001). Parent involvement in family support programs: an integrated theory. *Family Relations*., *50*, 113-121.

McLoyd, V.C. 1(998). Socioeconomic disadvantage and child development. *American Psychologist*, *53,* 185-204.

Meidel, W.T. & Reynolds, A.J. (1999). Parent involvement in early intervention for disadvantaged children: Does it matter?. *Journal of School Psychology, 37(4)*, 379-402.

Maxwell, J. A. (1996). *Qualitative research design. An interactive approach*. Thousand Oaks, CA: Sage.

Miles, M. B. & Huberman, M. A. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage Publications.

Napravnik, S., Royce, R, Walter, E., & Lim, W. (2000). HIV-1 Infected women and prenatal care utilization: barriers and facilitators. *AIDS Patient Care and STDs, 14,* 411-420.

National Center for Education Statistics (NCES), U.S. Department of Education. (2003). *Early Childhood Longitudinal Study Birth* Cohort.

Olds, D.L., Kitzman, H., Hanks, C., et al. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up -up of a randomized trial, *Pediatrics*, *120*, 832-845.

Padilla, Y.C., Radey, M.D., Hummer, R.A., & Kim, E. (2005). *The living conditions of US-born children of Mexican immigrants in unmarried families.* Center for Research on Child Wellbeing, Working Paper #05-13.

Pincus et al. (2005). *Improving Maternal Child Health Care: A blueprint for community action in the Pittsburgh Region.* RAND corporation, Santa Monica, CA.

Radloff, L.S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401.

Raikes, H. *Child Development*, July/August 2006; vol 7. News release, Society for Research in Child Development.

Reynolds, A. J., Ou, S., & Topitzes, J. W. (2004). Paths of effects of early childhood intervention on educational attainment and delinquency: A confirmatory analysis of the Chicago Child-Parent Centers. *Child Development, 75* (5), 1299-1328.

Richman, H. & Stagner, M. (1986). *Help-Seeking and the Use of Social Services Providers by Welfare Families in Chicago*. Chicago: Chapin Hall Center for Children.

Roggman, L.A., Cook, G.A., Peterson, C.A., Raikes, H.H. (2008). Who Drops Out of Early Head Start Home Visiting Programs? *Early Education & Development*, *19* (4), 574 - 599

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice, 23* (3), 325-348.

Shlay, A.B. & Weinraub, M. (2008). The catch-22 of welfare to work. *Miller-McCune, 1*, 34-37.

Spielberger, J., Haywood, T., Schuerman, J., Michels, L. & Richman, H.(2005). *Evaluation of the Children's Behavioral Health Initiative, Palm Beach County, Florida: Final Report*. Chicago: Chapin Hall Center for Children.

Spielberger, J., Lyons, S., Gouvea, M., Haywood, T., & Winje, C. (2007). *The Palm Beach County Family Study: Second Annual Report.* Chicago, IL: Chapin Hall Center for Children.

Staudt, M. (1999). Barriers and facilitators to use of services following intensive family preservation services. *The Journal of Behavioral Services & Research,* 26 (1): 30-49

Tandon, D. (2004). *Access to prenatal care in Palm Beach County: Findings and recommendations.* Baltimore, MD: Johns Hopkins University School of Medicine.

The Henry J. Kaiser Family Foundation. (2003). Florida: Distribution of nonelderly uninsured by age, state data 2002-2003, U.S. 2003. Retrieved March 10, 2007, from http://www.statehealthfacts.org

U.S. Census Bureau.(2008). Newsroom. Retrieved May 2, 2008, from www.census.gov/Press-Release/www/releases/archives/children.

U.S. Department of Agriculture, Center for Nutrition Policy and Promotion. (2004). *Expenditures on children by families: 2004 Annual report.* Downloaded 3/30/2007 from: www.usda.gov/cnpp/using2.html.

United Nations. (2002). Access to social services by the poor and disadvantaged in Asia and the Pacific: Major trends and issues. *Social policy paper, No 1*.

Weisner, T.S. (1984). A cross-cultural perspective: Ecocultural niches of middle childhood. In Andrew Collins (Ed.). *The elementary school years: understanding development during middle childhood*, (pp. 335-369).Washington, DC: National Academy Press.

Weisner, T. (1997).The ecocultural project of human development: Why ethnography and its findings matter. *Ethos, 25*(2), 177-190

Weisner, T. (2002). Ecocultural understanding of children's developmental pathways. *Human Development, 45* (4), 275-281.

APPENDIX A

Longitudinal Study Sample and Methods

Longitudinal Study Sample and Methods

The longitudinal study examines a broad array of health, educational, child care, and psychosocial services received by families with young children in the TGAs of Palm Beach County. In the short-term, the study will describe the children and families in the TGAs who use various services and examine child and family risk factors, service needs, and services received, and experiences using services. In the long-term, the study will (1) explore relations between early service use and later service use, and (2) relate service use and patterns of service use to child and family functioning and outcomes. Below are the primary research questions for the study.

1. What are baseline demographic characteristics of families of young children in the TGAs?
2. What services are available and used by families of young children in the TGAs?
3. Are there patterns of service use? What combinations, if any, of services occur most frequently? How does service use change over time?
4. Who are the children and families who use social services in the TGAs? What is the relation between child and family characteristics and service use (i.e., number and types of services used)? What characteristics determine service use?
5. What are pathways to service use? What are inhibiting and facilitating factors in use of services? In Year 2, we explored these questions primarily in the analysis of qualitative data, but in the future we will look in the survey data for relationships between or among variables of service use, social support, maternal depression, parenting stress, parenting activities, health, and child care.
6. What are the potential effects of service use? How is service use related to child outcomes such as physical, socio-emotional, and behavioral health, school readiness, and school success; and to family functioning and abuse/neglect rates?

To address these questions, the longitudinal study is using a mixed-methods approach to gather a wide variety of information about the characteristics and needs of families the system is intended to serve, and how families use services. Methods include the following:

- An analysis of administrative data on service use and key outcomes of all children born in the TGAs and in the county during 2004 and 2005 and who remain in the county at various data collection points during an 8-year period. To date, we have collected and analyzed available administrative data from Department of Health Vital Statistics, the database for the Healthy Beginnings system (Right Track and now FOCiS), and the Department of Children and Families (DCF) HomeSafenet database on reports of child abuse and neglect. We have also collected data from the EFS child subsidy system, which will be analyzed in the coming year.
- An 8-year longitudinal survey of the service use experiences of a sample of families with young children in the TGAs, employing annual in-person interviews with a baseline sample of 531 mothers of newborn children and brief telephone interviews with the same parents about 6 months after each in-person interview for 5 years, and administrative data on service use and child and family outcomes for 8 years.
- A 3-year qualitative study involving six in-depth interviews and observations of a small sub-sample of families to enhance what is learned through analysis of the household survey and administrative data about service use, motivations to use services, and how services fit into families' lives.

- Reviews of literature on barriers to and facilitators of service use, including findings about service use from evaluation reports of individual programs funded by the Children's Services Council (CSC) of Palm Beach County during the period of the study, for example, the Children's Behavioral Health Initiative, Comprehensive Services, and the Family & Community Partnership, as well as other research on services in Palm Beach County.

The three primary sources of data for the longitudinal study—administrative data, structured interview data, and in-depth qualitative interviews—are designed to complement and supplement one another. For example, data from the interview sample will provide additional information to help us identify correlates of child and family outcomes and better understand relations among services, child and family indicators, and outcomes found in the administrative data. At the same time, administrative data will provide additional information about service use and outcomes for mothers in the interview sample. The qualitative study will extend what we learn from both administrative data and the structured interview study about families' day-to-day lives, how service use does or does not fit into their lives, and other family characteristics and activities that affect family functioning and child development. Additional information on the methodology of each of the three study components is presented below.

Administrative Records

The sample for the administrative data component of the study is a population cohort of all families in Palm Beach County who had a child born between January 1, 2004 and December 31, 2005, with a focus on the subsample of families living in the TGAs at the time of their child's birth. Through data sharing agreements established with several agencies in Palm Beach County, including the Department of Health (DOH), Department of Children and Families (DCF), CSC, the School District of Palm Beach County, and Boys Town South Florida, we receive and analyze periodic exports of data birth cohort characteristics, service use, and child and family outcomes.

This second report of the longitudinal study draws on three sources of administrative data. First, the DOH Vital Statistics database provided information on the use of prenatal care, birth outcomes, and maternal demographic characteristics. Second, the FOCiS (formerly known as Right Track) database provided information on prenatal and postnatal assessments, names of agencies providing maternal child health services, types of treatment and non-treamtment services, and dates of service received in 2004 and 2005. Codes for activities defined as treatment in FOCiS are shown in Table A-1. Third, the DCF HomeSafenet database supplied information on reports of child abuse and neglect in 2004 and 2005.

In future years of the study, we will continue to gather information from these data sources for all families who remain in Palm Beach County. In addition, if available, information from other administrative data sources will be added to the study. These will include the HCD Welligent databases for the School Health, Behavioral Health, and Comprehensive Services programs, School District database on children's school readiness, behaviors, and academic progress, the Child Care Management System of children receiving subsidized child care, and Boys Town.

Table A.1 FOCiS Codes for Healthy Beginnings Services Defined as Treatment

Activity Code	Code Description	Program[a]
10	Nutrition	WHIN
11	Breastfeeding Peer Counseling	WHIN
12	Translation Services	WHIN
13	Smoking Cessation	WHIN
14	General Health Education	WHIN
15	Case Management	WHIN
16	Depression Screening	WHIN
16	Prenatal Depression Screening	HS
17	Depression Counseling	WHIN
18	Adolescent Pregnancy Prevention	WHIN
19	Pregnancy/Childbirth 4	WHIN
20	Parenting Skill Building/Education	WHIN
21	Male Support Services	WHIN
40	Nutrition	WHIN
41	Breastfeeding Peer Counseling	WHIN
42	Translation Services	WHIN
43	Smoking Cessation	WHIN
44	General Health Education	WHIN
45	Case Management	WHIN
46	Depression Screening	WHIN
46	Interconceptional Depression Screening	HS
47	Depression Counseling	WHIN
48	Adolescent Pregnancy Prevention	WHIN
49	Pregnancy/Childbirth 4	WHIN
50	Parenting Skill Building/Education	WHIN
51	Male Support Services	WHIN
3102	Participant Need Assmnt	HS
3215	Inital Assessment	HS
3215	Initial Assessment	WHIN
3320	Care Coordination - Face To Face	WHIN
3320	Care Coord: Face to Face	HS
3321	Care Coordination - Not Face To Face	WHIN
3321	Care Coord: Not Face to Face	HS
3322	Initial Family Suport Planning	HS
3322	Initial Family Support Planning	WHIN
3323	Update Family Support Planning	HS
3323	Update Family Support Planning	WHIN
4501	Nutrition Assessment Counseling	HS
6515	Oral Translation Services	HS
6516	Written or Assisted Translation	HS
8002	Psychosocial Counseling	HS
8004	Parenting Support and Education	HS
8006	Childbirth Education	HS
8008	Breast Feeding Education and Support	HS
8013	Interconceptional Education and Counseling	HS
8026	Smoking Cessation Counseling	HS

[a] HS=Healthy Start program; WHIN=Women's Health Initiative

The analysis of administrative data depends on accurately and reliably linking individual-level identifiers in data records across multiple service system databases. Linking is done through a process of probabilistic record matching, which calculates the probability that two records belong to the same person by using multiple pieces of identifying information. The most uniform common identifiers include name, social security number, date of birth, gender, race/ethnicity, and zip code, but these vary across administrative data systems. Because of data entry errors, administrative data systems may have errors in client identifying information, which can result in more than one system-unique ID for the same person. Probabilistic matching technology corrects for these "duplication" errors by linking records in different systems based on the probability of similar identifiers representing data records for the same person.

Structured Interviews

The structured interview component involves more intensive data collection on a sample of 531 families with children born in the TGAs during 2004 and 2005. The primary source of information on these families is an annual in-person interview, which is supplemented by data obtained from administrative records. The study sample was recruited through two maternal health programs in Palm Beach County, the Healthy Mothers/Healthy Babies Coalition and Healthy Start/Healthy Families between July 2004 and November 2005.[1] The baseline report of May 2006 (Spielberger, et al., 2006) provides other information about the recruitment process and recruitment issues for the study.

The sample was stratified along two dimensions. First, we assumed that families with more risk factors were more likely to have contact with services. Thus, we attempted to develop the sample so that about half would be families identified as "high risk" (children at high risk of poor outcomes or families at high risk of dysfunction) on a hospital screen or home assessment. Second, because the Glades TGA is sparsely populated and historically more transitory than other areas of the county,[2] we wanted to ensure that the sample was large enough to make reasonable estimates of its characteristics. Hence, the sample was structured according to the proportions shown in Table A-2.

Data for identifying families as "high risk" and "not high risk," were based on screens and assessments that are conducted at various points during pregnancy, at birth, and after birth and recorded in an administrative data system called Right Track. Mothers who receive

[1] We followed this approach as an alternative to obtaining permission to sample from birth records for several reasons. First, we did not know whether we would be able to attain Institutional Review Board (IRB) approval under the Health Insurance Portability and Accountability Act (HIPAA) to use protected health information for sample identification and recruitment. We also were following the precedent of an earlier study about access to prenatal care in Palm Beach County (Tandon, 2004), which recruited and interviewed newly delivered mothers in maternity wards. Finally, we recognized that because of their experience working with mothers in the TGAs, the hospital liaisons and nurses might be more trusted by potential respondents than other recruiters.

[2] In contrast to the other three TGAs, the Glades TGA in the western part of the county is a large, but sparsely populated agricultural area that includes several migrant families who harvest sugar cane, citrus fruit, and other crops. According to data from the 2000 Census, the percentage of families with children under the age of 18 living in poverty is higher in the Glades (46%) than in the other TGAs (25%) (CSC, May 2006). These percentages compare with an overall percentage of 13% for the proportion of all families with children under the age of 18 who live in poverty in the county as a whole.

Table A-2. Interview Study Sampling Plan

TGA	High Risk	Not High Risk	Total
Non-Glades	40%	40%	80%
Glades	10%	10%	20%
Total	50%	50%	100%

prenatal services from the Department of Health usually receive an assessment of risk during those contacts. Many mothers also are given the Healthy Start Infant Risk Screen in the hospital shortly after giving birth. On a scale from 0 to 10, a score of 4 or higher is considered an indicator of possible risk. Mothers who score 4 or higher are encouraged to accept a home visit from a Healthy Start nurse. Mothers who receive lower scores are not offered a home visit, but may request one.[3] Subsequently, in a home visit, mothers are designated as having services levels of E, 1, 2, or 3 on the basis of scored risk assessments, observations by nurses (and perhaps other medical personnel), and clinical judgments of nurses. Mothers who are assigned levels 2 and 3 are thought to need more frequent or more varied services and thus are loosely referred to as "high risk."[4]

Although mothers were to have recently given birth to a child and have custody of that child, these babies did not have to be first-born children. Other selection criteria included a maternal age and language. Mothers had to be 16 years and speak one of the three main languages spoken in Palm Beach County—English, Spanish, or Haitian Creole.

Each year, mothers are interviewed in person for about an hour to an hour and a half. Six-months after an in-person interview, they participate in a brief telephone interview lasting 20 to 30 minutes. The baseline in-person interviews were conducted soon after recruitment when the target child was between1 and 6 months of age. A telephone interview occurred 6 months later when the target child was between 7 and 12 months old. The third interview or second in-person interview occurred when the target child was between 13 and 18 months of age. Structured interviews are conducted by trained interviewers employed by Westat, a large survey research firm headquartered in Rockville, Maryland.

Topics for the first three rounds of in-person interviews are listed in Table A-3. A copy of the Year 3 interview can be found at the end of this Appendix. Interview topics were developed by Chapin Hall researchers with input from CSC and Westat research staff and with

[3] At the time we began recruiting, the Healthy Start program included a universal home visiting component for all newly delivered mothers. In spring 2005, the program changed to target mothers most in need of and more likely to use services. Mothers in a "special low risk" group were also offered a home visit if they were younger than 19, new to the county, have delivered their first child with no or only late-term prenatal care, have no identified pediatrician, have difficulty bonding with their baby, or seem to lack social support (personal communication with Tanya Palmer and Christine Walsh, 2005).

[4] Clearly, none of these measures of risk is perfect in identifying children and families that may need services. The screenings, assessments, and level designations all involve judgments, which are of unknown reliability and validity. In addition, not all mothers receive prenatal services. Not all are given the in-hospital screen. Some mothers refuse the assessment. Hospital liaisons are not present on weekends, and although other hospital personnel are supposed to visit mothers who give birth on weekends, those contacts do not always happen. Nor do all mothers agree to the postpartum visit by nurses. Those mothers who do agree are not always visited for a variety of reasons. Thus, the selectivity at each of these stages is likely to be biased and cannot be assumed to be random.

Table A-3. Baseline, 6-month Follow-up, Year 2, Year 2 6-month Follow-up and Year 3 Parent Interview Topics

Topic/TC Age	Year 1 In-person/0-6 mo.	Year 1.5 Phone/6-12 mo.	Year 2 In-pers/12-18	Year 2.5 Phone/18-24	Yr 3 In-pers/24-30
Household Composition	Description of all household members including name, relationship to the respondent, age, gender, race, student and employment status, number of hours worked per week, educational level; maternal nativity	Description of new household members; update on employment status of current household members	Same as Year 1	Same as Year 1 6 month, added item on country of origin for immigrants	Same as Year 2
Family Context	Family structure and social and economic context, including children who do not live in the home, the children's father(s), marital status, employment, language spoken in the home, access to transportation; living conditions;	Family structure and social and economic context, including children not in the home, the children's father(s), marital status, employment	Same as Year 1	Same as Year 1 6 month	Similar to Year 2; added items on mother's literacy
Adequacy of Living Arrangements	Conditions of family's housing — electricity, plumbing, heating/air conditioning, cooking appliances, lack of basic household furnishings, and overcrowding.	[No items in 6-month interview.]	Same as Year 1	Same as Year 1 6-month	
Health Status, Insurance, Prenatal Services, Child Development	(1) The general health of and medical care for infant, health problems of other children in the family, and general health of family; (2) mother's prenatal care; (3) health insurance coverage for children in the family and the parent's knowledge of public health insurance programs for children; and (4) where medical care is usually obtained and barriers to medical care.	(1) The general health and health problems of infant, other children, and mother; (2) health insurance coverage for children	Similar to Year 1; fewer items about prenatal care but mother asked if she has had another baby	Same as Year 1 6-month	Similar to Year 2, but added small number of items on child development (2-year milestones, language, toilet training)
Family Concerns and Knowledge and Use of Formal Services	(1) Concerns in the past year about (a) meeting family needs such as food, clothing, housing, medical and mental health care, child development, child care, and social relationships; and (b) child(ren)'s development, physical and mental health, social relationships, and school; (2) frequency of concern; (3) whether they tried to get help from a community agency or program; (4) whether they received help; (5) satisfaction with the agency or program; and (6) contacts with any other services.	(1) Whether family received help from a community agency or program to address concerns (a) about meeting family needs; and (b) about child(ren)'s development, physical and mental health, social relationships, and school; (2) contacts with any other specific social services; (3) whether hurricanes contributed to need for help.	Same as Year 1 (added birth control and family planning to Section C)	Same as Year 1 6-month	Same as Year 2
Child Care and After School Arrangements	(1) For preschool children, the type of care arrangement, the amount of time in care, cost of care, and satisfaction with the arrangement; and (2) for school age children, participation in organized activities or programs after school, adequacy of after-school opportunities, and satisfaction with after school arrangements.	For preschool children only, the type of care arrangement, the amount of time the child is in care, the cost of care, and their satisfaction with the arrangement	Same as Year 1	Same as Year 1 6-month	Same as Year 2, with one correction to get use of subsidies for all Rs using child care
Social Support	(1) Frequency and range of support parents receive from spouse or partner, relatives and friends, places of worship, and other community supports such as medical, school, and social work professionals; (2) satisfaction with help from these supporters, and (3) accessibility and adequacy of support.	[No items in 6-month interview.]	Similar to Year 1 interview items (dropped separate religious items; added affection and conflict items)	Same as Year 1 6-month	Similar to Year 2; dropped 2 items
Caring for Children	Mother's and partner's positive and negative parenting practices.	Mother's parenting practices only.	Same as Year 1, with some new items	Same as Year 1 6-month	Same as Year 2, with some new items and frequency scale
Public Financial Support and Family Income	Receipt of public transfers such as food stamps, rent vouchers, TANF, WIC, and Social Security, and to estimate their total household income from all sources.	Receipt of public transfers such as food stamps, rent vouchers, TANF, WIC, and Social Security in past 6 months	Same as Year 1	Same as Year 1 6-month	Same as Years 1 and 2
Depression and Alcohol Use	(1 Center for Epidemiological Studies Depression Scale (CES-D) to assess depressive symptoms in previous week; and (2) use of alcoholic beverages	CES-D scale only.	Same as Year 1, plus the Parenting Stress Inventory (PSI) to assess stress in daily parenting.	CES-D scale only	Same as Year 2, plus additional questions on smoking

reference to protocols used in other large-scale evaluations and studies of service use, children's development, and family functioning.[5] Before they were finalized, the consent and protocols for the baseline interview were piloted in spring 2004 with a small sample of mothers of infants residing in the TGAs of Palm Beach County. The interview topics cover a wide range of topics in an effort to develop a complete description of the demographic backgrounds of families and the variety of other factors that are likely to affect the well-being and development of their children and family functioning. In addition to the availability and use of formal services, these factors include family living conditions, physical and mental health, medical care, parenting practices, and access to informal and community support. In subsequent years of the study, the content of the structured interviews will remain largely the same so that change over time can be measured. However, some revisions will be made in selected items to reflect the developmental stage of the target child, changing family or community circumstances, or new information about service availability.

Sample Response Rates

Table A-4 presents the number of mothers who have completed each phase of the longitudinal study interviews to date. A total of 444 mothers, or 84 percent of the baseline sample of 531, completed the second in-person interview; and 399 (75%) completed the third-year in-person interview. A total of 390 (73%) of the mothers participated in all three waves of in-person interviews. As shown in Table A-4, the most frequent reason for sample attrition is mothers moving out of the study area or being unable to contact. Only a small percentage of mothers have declined to participate in follow-up interviews or left the study for other reasons.

Table A-3. Sample and Response Rates for First 4 Years of Longitudinal Study[a]

Interview Wave	Data Collection Period	Sample Retained	
		N	**%**
1. Baseline In-person Interview	July 2004-Nov. 2005	531	
2. First 6-Month Telephone	Jan. 2005-May 2006	484	91
3. Second In-person Interview	July 2005-Nov. 2006	444	84
4. Second 6-Month Telephone	Jan. 2006-May 2007	431	81
5. Third In-person Interview	July 2006-Dec. 2007	399	75
6. Third 6-Month Telephone	Jan. 2007-May 2008	*387*	*73*
7. Fourth In-person Interview	July 2007-Dec. 2008	*353*	*67*
8. Fourth 6-Month Telephone	Jan. 2008-May 2009	*In process*	

[a] A total of 702 mothers were recruited for the study, and 589 were selected for the original sample. Response rate is based on the rate for all eligible cases, which excludes mothers who no longer live in the study area, whose children were too old for the sample, who had lost custody of their children, or who were ineligible for another reason. Attempts are made to contact respondents for two consecutive time periods before they are dropped from the study sample pool.

[5] Other studies include the national evaluation of Family Preservation and Reunification Programs (Westat, Inc., Chapin Hall, & James Bell Associates, 2002), the Early Childhood Longitudinal Study, Birth Cohort (U.S. Department of Education, 2006), and the evaluation of the Cayuhoga County Early Childhood Initiative (Daro, Howard, Tobin, & Harden, 2005).

A regression analysis of the mothers who completed the second and third year interviews indicate that this attrition is almost random. In year 2, the only significant variable was marital status; mothers who were married were about twice as likely to be interviewed in year 2 as mothers who were not. In year 3, the only significant variable was ethnicity; African-American mothers were 2.5 times more likely than mothers of other ethnic backgrounds (largely Hispanic) to be interviewed in the third year.

Table A-4. Reasons for Sample Attrition for First 3 Years of Longitudinal Study

Interview Wave	Data Collection Period	Sample Loss		Reason for Attrition					
				Moved/Not Located		Refused		Other[a]	
		N	%	*N*	%	*N*	%	*N*	%
1. Baseline In-person	July 2004-Nov. 2005								
2. First 6-Month Phone	Jan. 2005-May 2006	47	9	35	75	10	21	2	4
3. Second In-person	July 2005-Nov. 2006	87	16	61	70	20	23	6	7
4. Second 6-Month Phone	Jan. 2006-May 2007	100	19	67	67	22	22	11	11
5. Third In-person	July 2006-Dec. 2007	132	25	94	71	28	21	10	8
6. Third 6-Month	Jan. 2007-May 2008	144	27	110	76	27	19	7	5
7. Fourth In-person	July 2007-Dec. 2008	171	32	130	76	31	18	10	6

[a] "Other" includes reasons such as "final not home, maximum contacts," and death of mother or child.

Qualitative Interviews and Analysis

We added a qualitative study of a small subsample of families in the spring of 2006 to provide a more in-depth and complete understanding of service use and other study topics. Using a mixed-sampling plan, we randomly selected fifty-eight English- and Spanish-speaking mothers from the full study sample; fifty-one mothers were located and agreed to participate in either the first or second qualitative interview. Because the qualitative study started a year after the larger study, and we wanted to interview mothers when their children were young, we limited the sample pool to mothers whose babies were born in 2005. We also excluded Haitian Creole-speaking mothers from the qualitative sample because they are a small proportion of the larger sample, and we did not have resources to hire a Creole-speaking interviewer. Thus, we divided the sample pool by initial risk level and then sampled Glades and non-Glades mothers in proportion to their representation in the larger study.

Qualitative interviewers meet with families twice a year to conduct in-depth, semi-structured interviews that last about 90 minutes.[6] All interviews are tape-recorded with the permission of mothers, transcribed, and validated to confirm the accuracy of the transcription. In the case of interviews conducted in Spanish, translation is carried out concomitantly with transcription. Interviewers also write detailed summary notes of the information collected during the interview and their observations of the home and neighborhood environment, parent-child interactions, and child behavior.

[6] The qualitative interviews are conducted by four trained graduate students from Florida Atlantic University and Florida International University. All have had previous experience with qualitative methodology, and two are fluent in Spanish.

The qualitative interviews are based on the Ecocultural Family Interview (EFI) framework.[7] They are designed to provide a more complete understanding of how families use, experience, and view services in their daily lives and how family and community contexts influence children's development and school readiness. The interviews examine families' perspectives on the following topics: daily routine and household information; beliefs, goals, and practices about child rearing; experiences with educational and child care services; work, economic well-being, and use of income support programs; use of health care and social services; and mobility and neighborhood characteristics. The interview format also allows family members to bring up and discuss topics that are of greatest concern to them. Additional data are collected through observations about the home environment, parent-child interactions, and child behavior during the home visits and recorded in summary field notes. A copy of the interview guide for the first two waves of qualitative interviews can be found at the end of this Appendix.

Interviews are taped recorded, transcribed, and organized in a database by theme, case identifier, date, and sub-group. For the interviews conducted in Spanish, translation is carried out concomitantly with transcription. Transcribed interviews are validated to confirm the accuracy of the translation and transcription. Thematic analysis is used to search for patterns, exemplary events, key activities, practices, beliefs, goals, and processes in the interview transcripts and summary notes.[8] Although the interview topics provide an initial guide for analysis, we also look for other themes and meanings that were not in the original protocol to emerge. In particular, we seek to identify the ecological and cultural factors that shape mothers' decisions to use (or not use) services.

We use the "grounded theory" approach to qualitative analysis (e.g., Glaser, 1965; Miles and Huberman, 1994; Morse, 1994; Patton, 2002), which builds theory based on a systematic approach to coding, usually termed "the constant comparative method." We examine interview transcripts and summary notes line by line to see what ideas and patterns the data reflect and develop codes for the data based on the ideas and patterns.[9] Although the interview topics provide an initial guide for analysis, we also look for other themes and meanings that were not in the original protocol to emerge. In coding, we try to capture both the *representational* meaning, or the content of what was said, and the *presentational* meaning, or how it was said, that is, mothers' use of language and narrative style (Freeman, 1996). As concepts are identified, they are compared and contrasted; and similar concepts are grouped together in categories. Along the

[7] Ecocultural Scale Project (1997), *The Ecocultural Family Interview Manual*, Los Angeles, CA: Ecocultural Scale Project; T.S. Weisner (1984), Ecocultural niches of middle childhood: A cross-cultural perspective, in W.A. Collins (Ed.), *Development During Middle Childhood*, Hillsdale, NJ: LEA Press; K. Nihira, T.S. Weisner, & L.P. Bernheimer (1994), Ecocultural Assessment in Families of Children with Developmental Delays, *American Journal on Mental Retardation*, 98, 551-566. We may also use an observational rating form such as the HOME (e.g., R. Bradley & B. Caldwell, 1988, Using the Home Inventory to Assess the Family Environment, *Pediatric Nursing*, 14,97-102).

[8] A qualitative data software program, Atlas.ti, is used to facilitate the systematic analyses and coding of the interviews.

[9] The Atlas.ti qualitative data software program is used to facilitate the systematic analysis and coding of the qualitative interview data.

way, memos are written to document relationships among concepts and categories and to document emerging ideas and patterns.

Our goals in the analysis and interpretation of the qualitative data are to both understand the experiences of mothers as individuals in the context of their daily circumstances and compare and synthesize the narratives of all of the mothers to form descriptions of "typical" or "composite patterns" of different kinds of service users. This occurs through a simultaneous process of deduction and induction. Although the qualitative interviews for this study cover a wide range of topics, we decided to limit the analysis of the first three waves for this report to the central topic of the longitudinal study—the service experiences of mothers. In particular, we focused on the barriers and facilitators to their use of various types of services—health care, economic supports, child-care, and social services—and how services fit into the context of their daily lives. In addition, we looked for emerging themes in their social support and parenting practices and beliefs because as we read the data about various types of services, developed codes, and analyzed the data, informal social support and parenting practices were emerging as important themes related to service use.

Thus, analyzing the qualitative data is an ongoing, evolving process of data reduction that occurs through developing codes, writing memos and summaries and making interpretations, based on the initial interview data, and then examining subsequent interviews, writing new summaries and interpretations, modifying existing categories, and developing new categories. Although we developed an initial list of concepts and themes based on reading the entire first three waves of interviews, we also relied on ecological theory (e.g., Weisner, 1997, 2002) and other research on service use, particularly the work of McCurdy and Daro (2001) and Anderson (1995), to refine and organize our categories. At the same time, coding the interview data was also an inductive process in which codes and categories emerge from the data. As additional data are collected over time, initial categories are elaborated further and augmented by mothers' responses to questions in subsequent interviews. Table A-5 displays just our preliminary list of barriers and facilitators to service use.

Because the longitudinal study encompasses a wide variety of services—in contrast to most other research on service use, which tends to focus on just one type of service—we developed matrices to organize the barriers and facilitators into their relevance to different kinds of services (health care, economic supports, child care, and social services), as well as according to types of barriers at different levels (individual, provider, program, and neighborhood factors) and their prominence in the experiences of different groups of mothers, for example English-speaking versus Spanish-speaking mothers, US born versus foreign-born (Table A-6 illustrates a partial cross-case matrix used to read data related to factors affecting WIC service use, and Table A-7 illustrates some of these factors for a small number of mothers.). We also developed a matrix-based framework based on interviewers' summary notes, which divided the summary notes data by wave, case, and interview domains (i.e. daily routine and household information; beliefs, goals, and practices about child rearing; experiences with educational and child care services; work, economic well-being, and use of income support programs; use of health care and social services; and mobility and neighborhood characteristics). The matrix allows the systematic reading of data by looking at differences and similarities across cases and across domains over time (Miles & Huberman, 1994; Lewis, 2007). We also checked our assumptions

Table A-5. Preliminary Categories for Coding Barriers and Facilitators of Service Use[a]

1.0 Individual Factors
- 1.1 Personal Enabling Resources
  - 1.11 Child care
  - 1.12 Personal concrete resources (transportation, telephone, income)
  - 1.13 Language proficiency
  - 1.14 Educational level
  - 1.15 Knowledge of services
  - 1.16 Instrumental support
  - 1.17 Health Status
  - 1.18 Available Time
  - 1.19 Immigration Status
- 1.2 Attitude, Perception, Beliefs, and Values
  - 1.21 Cost/Benefit perception
  - 1.22 Perception of value of services
  - 1.23 Perception about service personnel
  - 1.24 Cultural beliefs
- 1.3 Subjective Norms
  - 1.31 Family approval
- 1.4 Past Program Experiences

2.0 Provider Factors
- 2.1 Service Delivery Style
  - 2.11 Program presentation (program goals, knowledge of program scope)
  - 2.12 Communication style (impersonal, supportive, listener)
  - 2.13 Provider characteristics
- 2.2 Provider Behavior
  - 2.21 Responsiveness (non judgmental, respectful)
- 2.3 Provider Competency
  - 2.31 Language skills
  - 2.32 Cultural competency

3.0 Program Factors: Mothers' Perceptions
- 3.1 Program Structure
  - 3.11 Requirements
  - 3.12 Eligibility criteria
  - 3.13 Program Outreach
  - 3.14 Timing of Enrollment or Application
  - 3.15 Program Resources
    - 3.151 Physical accommodation (place to sit, resources for children)
    - 3.152 Translation services
    - 3.153 Number of staff
    - 3.154 Length of wait
    - 3.155 Staff training
    - 3.156 Program funding
  - 3.16 Intake procedures and office hours for application
    - 3.161 Method of information dissemination (written, oral, outreach)]
    - 3.162 Method of service application (computer, paper, presence of personnel)
  - 3.17 Communication Approach
    - 3.171 Written (letter, computer)
    - 3.172 Verbal (in person, telephone)
  - 3.18 Participant incentives (Child care)
  - 3.19 Duration between program acceptance and service receipt
- 3.2 Staff turnover (stability)
- 3.3 Geographical Location

4.0 Neighborhood Factors
- 4.1 Safety
- 4.2 Concrete Resources
  - 4.21 Transportation
- 4.3 Community Support and Norms

[a] Based on early analysis of the first three waves of qualitative interviews with 50 mothers.

Table A-6. Partial Matrix of Emerging Themes in Factors Affecting Use of WIC

Themes	Mother ID# and Wave		
	Wave One	Wave Two	Wave Three
Missed Appointments	247, 261, 269, 292		
Waiting Time	303		
Attitude, Perception, Beliefs, and Values	247	214	214
Knowledge of Program guidelines			
Language	214		
Transportation	214, 269,	214 , 269	214
Provider Responsiveness	247		

Table A-7. Examples of Factors in WIC Service Use for Individual Mothers

Mother ID#	Barriers	Facilitators
214	Wave I and II: Transportation, loss wages, language, provider is rude, far (location) [Non Use]. Wave III: Non Use but perception is changing due to need.	(Wave III): Niece will drive her to WIC. Will use WIC because of need.
247	Wave I: *Missed appointment* because should have taken daughter, call back no response (non use). Wave II: Start receiving food stamps therefore WIC will be denied (Non use). Same barriers (beliefs) over time (non use).	
261	*Wave I: Missed Appointment* confusion with the date (no use). Wave II: No need for WIC and take a long time and lots of requirement. Wave III: Report no need (non use)	
269	Wave I: *Missed appointment* reason not explicitly given, it seems due to transportation. Mother report concern with transportation (Service non use). Wave II: Language barriers (service use). Different barriers over time. Language may pose or not a barrier. Depends who will be at he office at the time of the application. Therefore, a barrier is also intermittent.	Wave I and II. WIC is fine, Depending on WIC's providers service may offer a barrier or not. Wave III: personal network providing baby sitting. Facilitator change over time (service use). Facilitator is intermittent.
292	Wave I: Brand of formula milk rejected by baby who was given different formula at the hospital (service use). Wave II: Not eligible (service non use). Not interviewed in wave III. Barriers changed over time. First wave it was milk choice and second wave was mother's income	Wave I: Help with milk (service use)
303	Wave I: Waiting (service use). Wave III: Transportation and neighborhood environment (safety), and appointment during work hours (service use).	Wave II: Thought that WIC has improved. Service is faster. Change from barrier to facilitator

and interpretations of mothers' narratives from the qualitative interviews against their survey and administrative data.

Because of limited resources, we could not allocate more than one researcher to coding all of the qualitative interviews. However, as described below, we used several strategies to ensure the credibility and quality of our data and data analysis. First, in the coding process, a second researcher read and coded a number of the interviews so that consistency in the application of codes could be assessed; this researcher also worked with the primary coder to

develop the list of codes, discussed the additional ideas, themes, and codes that emerged in the coding process with the primary researcher and other staff. Throughout the coding and analysis of the data, the primary researcher wrote memos about concepts and relationships emerging from the coding process; these memos were reviewed by the second researcher on an ongoing basis. Finally, we consulted the literature for further exploration and validation of emerging concepts, as well as checked our assumptions and interpretations of the qualitative data against the survey and administrative data.

More specifically with respect to inter-coder reliability, we assessed consistency in application of codes in three related ways. First, during data reading and analysis, as codes were developed and applied to a selected text, peer discussions were carried out periodically to ensure the workability and representativeness of the code scheme. During this step, the concepts and definitions of codes were refined within the context of the unfolding themes and patterns. Thus, the coding scheme was revised as new patterns and themes emerge. Furthermore, over time, as new data is collected and transcripts are reread, the code list was revised. Second, to verify code quality, accuracy, and representativeness, five interviews were randomly selected to estimate inter-coder agreement. Two researchers were given the same transcript to be coded using the primary list of code developed. We consistently compared each coded segment line by line to verify the correspondence between code and area coded. Given the time involved in such an endeavor, only a sample text of each of the four transcripts was selected to estimate inter-coder agreement. Perhaps because of regular peer discussions during codebook development and data interpretation, few inconsistencies occurred during this process. Most of these were due to missing codes, which may have to do with the fact that each researcher's knowledge and personal experience brings different perspective and interpretation to the data and thus coding is not always strictly comparable (Harris, Pryor, Adams, 1997; Lincoln & Guba, 1985; Glaser & Strauss, 1967). During this process the codebook was also refined as code concepts and definition were clarified. It should be noted that this activity was geared especially to verify the workability and sustainability of the codebook. Third, as topic bound codes were retrieved—using Atlas.ti—for analysis within a topic, code accuracy was checked concomitant with data reading and interpretation by the primary coder as well as peer review and discussion.

As part of our analysis of the qualitative data, we selected six cases from the qualitative sample to write narratives of mothers' circumstances across cultural and ecological domains over time. The purpose of the cases narratives was to highlight mothers about experiences with services and the factors that influence families' use of services, including material and social resources, and to capture change of mothers' circumstances. Developing the case narratives also entailed the coding of the interviews to check the applicability of the coding scheme and peer discussions to assess the writer interpretation of the participant's ecological and cultural world (Maxwell, 1996). In this study, six case narratives were written by four researchers across four waves of interviews. After the completion of each case narrative, another researcher, who was familiar with the case interviews, read the cases and discussed it with other research staff. In these discussions, we also attempted to verify emerging themes and patterns estimate narrative reliability during report writing.

At the time of this report, data collection and analysis are still going on. Some of our interpretations of the early data regarding service barriers and facilitators may change with

subsequent analysis with the addition of more interviews and the coding of additional themes and categories of information. That is, according to our ecological model, in order to fully understand the barriers and facilitators of service use and the multiple factors that affect families' and children's outcomes, it is necessary to understand how services fit into other aspects of families' lives. Thus, in addition to examining experiences with medical, social, and educational services, future analyses will also look at such topics as the adequacy and stability of families' daily routines to meet their children's needs, ease of parenting and caring for children, family connectedness and amount of instrumental and emotional support from family and friends, the adequacy and predictability of household income, the effect of maternal employment on children, neighborhood safety and opportunities for children, and cultural influences on parenting and service use.

Furthermore, by looking at families' experience with services and life circumstances *over time* we expect to better understand factors that change and affect families' circumstances and outcomes. As we advance with our qualitative data analysis, we find that mothers' and children's well-being vary with changes in their living situation, such as moving to a new neighborhood, changing income resulting from a change in job or marital status, or change in the availability of social support (e.g. child care support). Likewise, change in mothers' circumstances over time will change factors that hamper or facilitate service use. For example, in the case of one mother, a move to a new neighborhood meant closer proximity to family. In turn, her family and friends (personal network) became a more salient factor affecting her service use than they had previously.

Thus, our analysis of the barriers and facilitators of service use are still preliminary and do not yet provide a complete account of the relative importance of various factors affecting service use by mothers in the TGAs. At the same time, it should be noted that, unless stated otherwise, all of the themes related to the barriers and facilitators of service use mentioned in the chapter were recurring themes in the accounts of our respondents.

Study of Services for Families and Children in Palm Beach County

THIRD YEAR MATERNAL INTERVIEW

Case ID:_____

Interviewer Name:_____

Date:_____/ _____/ _____

DID RESPONDENT SIGN CONSENT FORM?

☐ YES

☐ NO [RESPONDENT MUST SIGN CONSENT FORM BEFORE STARTING INTERVIEW]

RECORD START TIME: → |___|___|:|___|___|

SECTION A: DEMOGRAPHICS

[TARGET CHILD] IN THE FOLLOWING REFERS TO THE CHILD BORN PRIOR TO THE FIRST INTERVIEW; [CHILD] REFERS TO A NAMED CHILD, PERHAPS NOT THE TARGET CHILD

A1. According to my records, you have a child whose name is _____. Is this what you call him/her? IF THIS IS NOT WHAT THEY CALL THE TARGET CHILD, NOTE NAME HERE _____.

A2. Is [TARGET CHILD] living with you now?

YES ..... 1 (GO TO A4)
NO 0

A3. Where is [TARGET CHILD] living now?

WITH FATHER 1
WITH ANOTHER RELATIVE..... … 2
IN FOSTER CARE 3
OTHER (SPECIFY) _____ 4

A3a. Do you think [TARGET CHILD] will be returning to live with you in the next 6 months?

YES 1
NO 0
NOT SURE/DON'T KNOW 8

A3b. Is there anything you can tell me about [TARGET CHILD'S] living situation or why he/she is not currently living with you?

_____
_____
_____

OK, first I have a few questions about you.

A4. What is the main language you speak at home?

ENGLISH..... 1
SPANISH..... 2
HAITIAN CREOLE..... 3
FRENCH 4
PORTUGUESE 5
CONJUBAL 6
OTHER (SPECIFY) _____ 7

A5. Are you currently working?

YES 1
NO ..... 0 (GO TO A11)

A6. How many hours a week are you working, on average?

|___|___|
HOURS

A7. Do you have more than one paid job?

YES 1
NO ..... 0 (GO TO A9)

A8. How many jobs do you have right now?

|___|___|
JOBS

A9. Which of the following best describes the hours you usually work at your main job?

a. A regular daytime shift – any time between 6 A.M. and 6 P.M. 1
b. A regular evening shift – any time between 2 P.M. and Midnight.....2
c. A regular night shift – any time between 9 P.M. and 8 A.M. 3
d. A rotating shift – ....one that changes periodically from days to evenings or nights..... 4
e. A split shift – one consisting of two distinct periods each day 5
f. Some other schedule?..... 6
(SPECIFY) _____

A10. [On the job that you spend the most time at] What is it that you do on your job?

RECORD VERBATIM _____ _____

_____ _____

_____ _____

OCCUPATIONAL CODE – HOME OFFICE ONLY

To be coded by home office only

OCCUPATION and CODES

Executive, Administrative, and Managerial Occupations	01
Engineers, Surveyors, and Architects	02
Natural Scientists and Mathematicians	03
Social Scientists, Social Workers, Religious Workers, and Lawyers	04
Teachers	05
Health Diagnosing and Treating Practitioners	06
Registered Nurses, Pharmacists, Dieticians, Therapists, and Physician's Assistants	07
Writers, Artists, Entertainers, and Athletes	08
Health Technologists and Technicians	09
Technologists and Technicians, except Health	10
Marketing and Sales Occupation	11
Administrative Support Occupation, including Clerical	12
Service Occupations	13
Agricultural, Forestry, and Fishing Occupations	14
Mechanics and Repairers	15
Construction and Extractive Occupations	16
Precision Production Occupations	17
Production Working Occupations	18
Transportation and Materials Moving Occupations	19
Handlers, Equipment Cleaners, Helpers, and Laborers	20
Miscellaneous Occupations	21
NEVER WORK/HOMEMAKERS	22
REFUSED	97
DON'T KNOW	98

A11. Are you currently in school?

YES 1
NO ..... 0 (GO TO A15)

A12. Are you currently taking courses full-time or part-time?

FULL-TIME 1
PART-TIME 2

A13. How many hours a week are you in classes?

|___|___|
HOURS

A14. What kind of educational program or programs are you in? (CIRCLE ALL THAT APPLY)

a. High school 01
b. Ged prep 02
c. English as a second language 03
d. Vocational/technical 04
e. Two-year/associate's degree 05
f. Four-year undergraduate degree 06
g. Master's degree 07
h. Doctoral degree 08
i. Adult education 09

A15. Are you currently participating in a job-training or on-the-job-training program?

YES 1
NO 0

[SEE A4. IF RESPONDENT SPEAKS ENGLISH AS HER PRIMARY LANGUAGE, GO TO A17.]

A16. I would like you to tell me about your knowledge of English:

How well do you speak English? Would you say…

Very well 1
Well 2
A little 3
Not at all 4

A17. How well do you read English? Would you say…

Very well 1
Well 2
A little 3
Not at all 4

A18. How well do you write English?

Very well 1
Well 2
A little 3
Not at all 4

A19. Are you currently:

Married	1 →	(GO TO A21)
Divorced	2	
Separated	3	
Widowed	4	
Single and never married	5	

A20. Are you currently in a relationship with someone you consider your partner?

YES	1
NO	0 (GO TO A28 INTRO)

A21. Are you currently living with your [husband/partner]?

YES	1
NO	0

A22. Is your husband/partner working?

YES	1	
NO	0	(GO TO A25)

A23. How many hours a week has he worked in the past three months, on average?

|___|___|
HOURS

A24. How long has he worked at his main job? (CIRCLE ONE)

|___|___| DAYS / WEEKS / MONTHS / YEARS } (GO TO A28 INTRO)

A25. Has your husband/partner had a full-time or part-time job in the past?

YES	1	
NO	0	(GO TO A28 INTRO)

A26. When did that job end?

|___|___| |___|___|___|___|
MONTH YEAR

A27. How long did he work at that job? (CIRCLE ONE)

|___|___| DAYS / WEEKS / MONTHS / YEARS

A28 INTRO: Now, I'd like to know a little bit about everyone who lives in this household. Let's start with you.

HOUSEHOLD ENUMERATION TABLE
ASK ALL QUESTIONS FOR ONE PERSON BEFORE GOING TO THE NEXT PERSON

A28 (a) PERSON NUMBER	A28 (b) NAME	A28 (c) RELATIONSHIP TO MOTHER	A28 (d) AGE AND BIRTH-DATE	A28 (e) SEX	A28 (f) RACE/ETHNICITY	A 28 (g) RESIDENCE OF FATHER OF CHILD(REN)	A28 (h) HEALTH INSURANCE	A28 (i) SCHOOL	A28 (j) EDUCATION	A28 (k) EMPLOYMENT
	LIST ALL NAMES IN ORDER IN COL. 8 STARTING WITH THE MOTHER ON LINE 01	What is [NAME'S] relationship to you? SON/DAUGHTER (01), NIECE/NEPHEW (02), GRANDCHILD (03), FOSTER CHILD (04), HUSBAND/PARTNER (05), SISTER/BROTHER (06), MOTHER/FATHER (07), GRANDMOTHER/ GRANDFATHER (08), AUNT/UNCLE (09), OTHER RELATIVE OR IN-LAW (10), OTHER NON-RELATIVE (11) ENTER CODE	What is (NAME'S/your) age and what is (NAME'S/your) date of birth? ENTER AGE AND CIRCLE Yr FOR YEARS or Mo FOR MONTHS	ENTER SEX. ASK IF UNSURE M F	Do you consider (NAME/yourself)… Black, not Hispanic (1) Hispanic (2) White, not Hispanic (3) Asian, Pacific Isl., (4) American Indian, Eskimo or Aleut (5) Multiracial (6) or Other (SPECIFY) (7) ENTER CODE	ASK ONLY OF R's CHILDREN—THOSE CODED AS 01 in A26c Is [NAME'S] father living here? Y N	(Does NAME/do you) have health insurance? Y N	ASK ONLY OF PERSONS OVER AGE 4 Does [NAME] attend any kind of school? Y N	ASK ONLY OF PERSONS OVER AGE 5 What is the highest level of school (NAME/you) completed? NO SCHOOLING (NS) DAY CARE (DC) PRE-SCHOOL (PS) KINDERGARTEN (KG) 1-12 (ENTER # YRS COMPL) (01-12) H.S. GRAD (HG) GED (GD) VOC'L SCHOOL (VS) UNGRADED SPEC'L ED (SE) ATTEND COLL., BUT DID NOT GRAD (AC) COLLEGE GRAD (CG) ENTER CODE	ASK ONLY OF PERSONS OVER AGE 14 Is (NAME) currently… Employed (1) Unemployed and looking for work (2) Unemployed and not looking for work (3) ENTER CODE
(01)		SELF	AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2			1 0			
(02)		[TARGET CHILD] **01**	AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(03)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(04)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(05)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(06)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(07)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(08)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(09)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		
(10)			AGE |_____| Yr Mo |_|_|_|_|_|_|_|_|	1 2		1 0	1 0	1 0		

A29. Do you have any children under 18 who do not live here?

YES..... 1
NO..... 0

A30. [SEE THE TABLE A28 (G)] [IF A FATHER OF ANY OF R'S CHILDREN IS NOT IN THE HOME ASK] Do you receive child support from the father(s) of your child(ren)?

YES..... 1
NO..... 0
NA, FATHER IN HOME..... 6

[IF NOT A RESIDENCE AND RESPONDENT LIVES SOMEWHERE ELSE, e.g., WELFARE HOTEL, SHELTER, etc. SKIP TO A33.]

A31. Is this (apartment/house) rented, or do you or someone else in your household own it?

RENTED..... 1
OWNED..... 2

A32. How long have you been living at your current address? (CIRCLE ONE)

YEARS → [GO TO A35 IF MORE THAN ONE YEAR (12 MONTHS)]
____ MONTHS
____ DAYS

A33. How many different places have you lived in the last year?

____
PLACES

A34. In general, is it easy for you to get to places you want to go?

YES..... 1 (GO TO A36)
NO..... 0

A35. Why? (CIRCLE ALL THAT APPLY)

A. DO NOT OWN OR HAVE ACCESS TO A CAR (OR CAR DOESN'T WORK AND NEEDS REPAIRS) 1
B. DON'T DRIVE 2
C. PUBLIC TRANSPORTATION NOT EASILY ACCESSIBLE (E.G. IS NOT CLOSE TO WHERE I LIVE, BUS SCHEDULE NOT CONVENIENT) 3
D. COST IS TOO EXPENSIVE (DON'T HAVE CAB OR BUS FARE) 4
E. PHYSICAL LIMITATIONS (E.G. UNABLE TO WALK) 5
F. I AM AFRAID TO GO OUT 6
G. OTHER (SPECIFY) _____ 7

A36. These questions are about the place in which you live right now. Has this happened in the last year for more than a day at a time? Please do not include loss of electricity, water, appliances that result from a rare local event, such as a hurricane.

		Y	N
a.	The electricity did not work	1	0
b.	The plumbing did not work (by that I mean the toilet, bath, or shower)	1	0
c.	Cooking appliances, such as the stove, or the range, did not work	1	0
d.	Broken windows or doors were not fixed	1	0
e.	There were bare electric wires	1	0
f.	A lot of paint was peeling	1	0
g.	The heating/air conditioning has not worked	1	0
h.	Your home was overcrowded, that is, not enough room for everyone to sleep or have some privacy	1	0
i.	There were not enough basic necessities such as chairs, tables, beds, cribs, mattress, or things like blankets, sheets, pots or dishes	1	0
j.	The neighborhood was unsafe because of illegal activities going on	1	0

A37. Did you experience any loss greater than $50 as a result of hurricanes in the last year?

YES 1
NO 0

SECTION B: HEALTH AND INSURANCE COVERAGE

REMINDER: [TARGET CHILD] IN THE FOLLOWING REFERS TO THE CHILD BORN PRIOR TO THE FIRST INTERVIEW AND NAMED IN A1.

Now I have some questions about **[**TARGET CHILD] and [TARGET CHILD]'s health.

B1. Would you say [TARGET CHILD]'s health is…

a Excellent 1
b. Very good 2
c. Good 3
d. Fair 4
e. Poor 5

B2. During the last 6 months, how many times has [TARGET CHILD] gone for well-child checkups? These are visits to the doctor when [he/she] <u>isn't</u> sick, but to get [him/her] checked over or to get immunizations or shots.

|___|___|
TIMES

B3. Did a doctor or professional ever tell you that [TARGET CHILD] has any special medical needs? [PROBE: FROM THE TIME [TARGET CHILD] WAS BORN UNTIL NOW.]

YES 1
NO ..... 0 → (GO TO B5)

B4. What medical needs? [RECORD VERBATIM]: _____

_____

B5. We would like to know about IMMUNIZATIONS or shots [TARGET CHILD] has received to keep him/her from getting sick. Has [TARGET CHILD] ever had any baby shots?

YES 1
NO ..... 0 → (GO TO B7)

B6. Has [TARGET CHILD] gotten all the baby shots recommended for his or her age?

YES .....1 → (GO TO B8)
NO 0

B7. Why is it that [TARGET CHILD] has not had some or all of his or her baby shots? (CIRCLE ALL THAT APPLY)

WE DO NOT FEEL THOSE DISEASES WILL AFFECT THIS CHILD 1
RELIGIOUS BELIEFS.....2
BABY SHOTS DO NOT KEEP THE CHILD FROM GETTING SICK.....3
BABY SHOTS MIGHT MAKE THE CHILD SICK.....4
GETTING CHILDHOOD DISEASES IS NATURAL 5
WE JUST HAVE NOT THOUGHT ABOUT IT 6
WE JUST HAVE NOT GOTTEN AROUND TO IT 7
WE DO NOT HAVE INSURANCE TO PAY FOR THE SHOTS 8
OTHER , SPECIFY _____ 9

B8. Do you have any records of [TARGET CHILD]'s baby shots?

YES..... 1
NO..... 0

B9. [IF ANY OTHER CHILDREN] Do any of your other children have medical problems that require regular medical care?

YES..... 1
NO..... 0
NA, NO OTHER CHILDREN..... 6

B10. Where do you usually take your [child/children] for routine medical care? (CIRCLE ONLY ONE)

A. PUBLIC HEALTH DEPARTMENT CLINIC 01
B. OTHER CLINIC OR HEALTH CENTER 02
C. DOCTOR'S OFFICE 03
D. HOSPITAL EMERGENCY ROOM..... 04
E. HOSPITAL OUTPATIENT DEPARTMENT..... 05
F. SOME OTHER PLACE..... 06
G. DOESN'T GO TO ONE PLACE MOST OFTEN..... 07
H. DO NOT GET REGULAR MEDICAL CARE 08

B11. [IF ANY OTHER CHILDREN] Do any of your other children have health problems that you would like to talk with a doctor about but are unable to for any reason?

YES..... 1
NO ..... 0 (GO TO B13)
NA, NO OTHER CHILDREN..... 6 (GO TO B13)

B12. Why is it you are unable to talk with a doctor? (CIRCLE ALL THAT APPLY)

A. NO INSURANCE..... 01
B. TOO EXPENSIVE/CAN'T AFFORD IT 02
C. DON'T LIKE CURRENT DOCTOR..... 03
D. DON'T KNOW WHERE TO GO FOR HELP..... 04
E. DOCTOR'S OFFICE HOURS ARE NOT CONVENIENT TO MY SCHEDULE 05
F. TRANSPORTATION IS A PROBLEM 06
G. CAN'T FIND DOCTOR WHO TAKES MY INSURANCE 07
H. FEAR OF WHAT MIGHT BE WRONG 08
I. LANGUAGE (DOCTOR DOES NOT SPEAK MY LANGUAGE)..... 09
J. OTHER (SPECIFY) _____ 10

The next questions are about health insurance plans for children. For this kind of insurance, people often pay part of the premium and they may obtain it through work, purchase it directly, or receive it through a state or local government program or community program.

B13. [Is your child/Are your children] covered by any kind of health insurance or some other kind of health care plan?

YES/ALL ARE COVERED..... 1
SOME ARE COVERED..... 2
NO CHILDREN COVERED ..... 3 → (GO TO B15)

B14. What kind of health insurance or health care coverage [does TARGET CHILD/do your children] have? [Does he/she] [Do they] have coverage through... (CIRCLE ALL THAT APPLY)

a. Private health insurance plan or HMO (from employer, workplace, or purchased directly, or through a state or local government program or community program) 1
b. Medicaid 2
c. CHIP, Kidcare, Medikids, Healthy Kids, or Children's Medical Services ..... 3 → **(SEE BOX B14A BELOW)**
d. Military health care/TRICARE/CHAMPUS/ CHAMP-VA? 4
e. Indian Health Service 5
f. Palm Beach County Health Care District..... 6
g. Another government program (Medicare or other)..... 7

BOX B14A
IF B 13=1 GO TO **B17**
IF B13 ≠1 **AND** B14C IS MARKED, GO TO **B16**

B15. Have you ever heard of these insurance programs?

		YES	NO
a.	CHIP	1	0
b.	Kidcare	1	0
c.	Medikids	1	0
d.	Healthy Kids	1	0
e.	Children's Medical Services	1	0

B16. Please tell me the reasons your children aren't covered by health insurance. (CIRCLE ALL THAT APPLY.)

A. GOT DIVORCED/SEPARATED OR WIDOWED 01
B. GOT MARRIED OR REMARRIED 02
C. PERSON IN FAMILY WITH HEALTH INSURANCE LOST JOB OR CHANGED EMPLOYERS 03
D. EMPLOYER DOES NOT OFFER COVERAGE 04
E. NOT ELIGIBLE FOR COVERAGE BECAUSE CHILDREN NOT BORN IN U.S. 05
F. NOT ELIGIBLE FOR COVERAGE FOR OTHER REASON 06
G. COST IS TOO HIGH 07
H. INSURANCE COMPANY REFUSED COVERAGE 08
I. LOST MEDICAID OR MEDICAL PLAN BECAUSE OF NEW JOB OR INCREASE IN INCOME 09
J. LOST MEDICAID (OTHER REASON) 10
K. BECAME INELIGIBLE FOR KIDCARE, OR MEDIKIDS 11
L. DIDN'T KNOW CHILD WAS ELIGIBLE FOR KIDCARE, OR MEDIKIDS 12
M. TRIED BUT DID NOT QUALIFY FOR CHIP, KIDCARE, MEDIKIDS, HEALTHY KIDS, OR CHILDREN'S MEDICAL SERVICES 13
N. TOO MUCH TROUBLE TO GET ON PROGRAM 14
O. DON'T KNOW HOW TO APPLY 15
P. CHILD/CHILDREN ON WAITING LIST 16
Q. CHILD WAS NOT SICK 17
R. PAPER WORK IS IN PROGRESS 18
S. HAVE HEARD BAD THINGS ABOUT IT 19
T. OTHER (SPECIFY) _____ 20

Now I have some questions about your health and your family's.

B17. Would you say your health in general is ….

a. Excellent 1
b. Very good 2
c. Good 3
d. Fair 4
e. Poor 5

B18. Where do you usually get routine medical care for yourself? (CIRCLE ONLY ONE)

A. PUBLIC HEALTH DEPARTMENT CLINIC 01
B. OTHER CLINIC OR HEALTH CENTER 02
C. DOCTOR'S OFFICE 03
D. HOSPITAL EMERGENCY ROOM 04
E. HOSPITAL OUTPATIENT DEPARTMENT 05
F. SOME OTHER PLACE 06
G. DOESN'T GO TO ONE PLACE MOST OFTEN 07
H. DO NOT GET REGULAR MEDICAL CARE 08

B19. Do you have a physical or mental health problem now that keeps you from working or attending school or limits the kind or amount of work you can do?

YES 1
NO 0

B20. Do any household members have a special medical or mental health need, delay, or disability?

YES 1
NO 0

See A28. IF A28 INDICATES THAT R HAS **NOT** HAD ANOTHER BABY SINCE [TARGET CHILD] GO TO B23

B21. You said you have had another baby. About how many weeks into that pregnancy did you [first] go for prenatal care? Don't count a visit only for a pregnancy test.

|___|___|
WEEKS

B22. Did your doctor tell you that this new baby was a high-risk pregnancy?

YES 1
NO 0

B23. Are you pregnant now?

YES 1
NO .....0 (GO TO B PART 2 CHILD DEV)

B24. Are you currently receiving prenatal care from a doctor or clinic for this pregnancy?

YES 1
NO .....0 (GO TO B PART 2 CHILD DEV)

B25. About how many weeks into this pregnancy did you [first] go for prenatal care? Don't count a visit only for a pregnancy test.

|___|___|
WEEKS

B26. Has your doctor told you that this is a high-risk pregnancy?

YES 1
NO 0

SECTION B PART 2 CHILD DEVELOPMENT [ECLS-B]

Let's talk about [TARGET CHILD]. In this study we want to learn what kinds of things toddlers can do at different ages. I'd like you to think back to when [TARGET CHILD. was able to do various things and tell me how old in months {he/she} was when {he/she} first started to do these things. If {he/she} can't do something yet, just say "not yet."

ENTER 95 IF CHILD HAS NOT DONE YET.

B27. How old was [TARGET CHILD] in months when (he/she)…

a. Started walking up stairs alone?.....|___|___| MONTHS

b. Started saying {his/her} first words? .....|___|___| MONTHS

c. Started turning pages of a picture book, one at a time? .....|___|___| MONTHS

d. Started opening a door by turning the knob and pulling? .....|___|___| MONTHS

e. Started playing with other children and
doing things with them (e.g., cars, dolls, building)? .....|___|___| MONTHS

f. Started pretending when (he/she) plays (for example, using an object as
if it were something else such as using a block for a phone, a cardboard
box for a car or a doll bed, a napkin for a doll blanket)? .....|___|___| MONTHS

B28. Some toddlers are starting to learn to go to the toilet by themselves. Which of the following is most true about your family?

You have not yet begun toilet training with [TARGET CHILD] (for example,
because {he/she} is too young) 1
You are working on toilet training with [TARGET CHILD] 2
[TARGET CHILD] can use the toilet by {himself/herself} now 3

B29. We also want to know how children learn to communicate. How often does [TARGET CHILD] combine words, such as "nother cracker" or doggie bite"?

Several times a day 4
Once a day 3
Once to several times a week 2
Once or twice a month 1
Has not done this yet 0

B30. Which of these statements best describes the way [TARGET CHILD] communicates?

Mostly talking in one-word sentences, such as "milk" or "down".....1
Talking in 2 to 3 word phrases, such as "give doll" or "me got ball". 2
Talking in fairly complete, short sentences, such as "I got doll" or "can I go outside?" .3
Talking in long and complicated sentences, such as "when we went to the park,
I went on the swings" or "I saw a man standing on the corner".....4

SECTION C: NEEDS, PROBLEMS AND USE OF FORMAL SERVICES

Now, I'd like to ask you about concerns that you might have and about help for these concerns in the community. I will read you a list of concerns that people sometimes have.

Area	**A.** In the past year did you receive help from a program, agency or professional with …		**B.** In the past year has this been a concern?…		**C.** In the past year, did you try to get help for this concern from a program, agency, or other professional?		**D.** ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional?			
	YES (1)	NO (0)	YES (1)	NO (0)	YES (1)	NO (0)				
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item		Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
a. Paying your rent or bills	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Buying clothes for your child(ren)	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. Getting enough food	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. Housing	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

_____

_____

_____

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

_____

_____

_____

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

_____

_____

Area	A. In the past year did you receive help from a program, agency or professional with … YES (1)	A. NO (0)	B. In the past year has this been a concern?… YES (1)	B. NO (0)	C. In the past year, did you try to get help for this concern from a program, agency, or other professional? YES (1)	C. NO (0)	D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional? Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item					
e. Emergency shelter	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. Employment	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. Health care for you or your child(ren)	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
h. Dental care	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
i. Mental health or substance abuse	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

_____

_____

_____

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

_____

_____

_____

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

_____

_____

Area	A. In the past year did you receive help from a program, agency or professional with … YES (1)	A. NO (0)	B. In the past year has this been a concern?… YES (1)	B. NO (0)	C. In the past year, did you try to get help for this concern from a program, agency, or other professional? YES (1)	C. NO (0)	D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional? Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item					
j. Parenting information	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
k. Family planning or birth control	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
l. Child care	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
m. Legal issues	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
n. Transportation	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

_____

_____

_____

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

_____

_____

_____

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

_____

_____

Area	A. In the past year did you receive help from a program, agency or professional with …		B. In the past year has this been a concern?…		C. In the past year, did you try to get help for this concern from a program, agency, or other professional?		D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional?			
	YES (1)	NO (0)	YES (1)	NO (0)	YES (1)	NO (0)				
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item		Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
o. Your reading or writing skills	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
ASK ONLY IF NOT FLUENT IN ENGLISH p. Translating things into English	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

_____

_____

_____

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO *C2*]

_____

_____

_____

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

_____

_____

SECTION D: PARENT CONCERNS AND COMMUNITY PROGRAMS

I have a few questions to ask you about concerns you may have about your children. Some people have special concerns about their children, while other people do not. I will read off a list of possible concerns parents might have. As I read the list of possible concerns could you tell me if in the last year have you received help from a program, agency, or professional.

Area	A. In the past year did you receive help from a program, agency or professional with …		B. In the past year has this been a concern?…		C. In the past year, did you try to get help for this concern from a program, agency, or other professional?		D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional?			
	YES (1)	NO (0)	YES (1)	NO (0)	YES (1)	NO (0)				
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item		Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
a. Your child's physical health or illness	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Your child's physical development (e.g., ability to sit, crawl, walk, pick up toys)	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. Your child's language and communication	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. Your child getting along with peers, siblings, or adults	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

Area	A. In the past year did you receive help from a program, agency or professional with …		B. In the past year has this been a concern?…		C. In the past year, did you try to get help for this concern from a program, agency, or other professional?		D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional?			
	YES (1)	NO (0)	YES (1)	NO (0)	YES (1)	NO (0)				
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item		Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
e. Your child getting upset or angry	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. Your child's withdrawal, sadness or depression	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. Your child's problems paying attention	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

Area	A. In the past year did you receive help from a program, agency or professional with …		B. In the past year has this been a concern?…		C. In the past year, did you try to get help for this concern from a program, agency, or other professional?		D. ASK ONLY IF HELP WAS RECEIVED IN A: How satisfied were you with your contact with this agency, program, or professional?			
	YES (1)	NO (0)	YES (1)	NO (0)	YES (1)	NO (0)				
	(⇒ **IF YES**, list agency/ program/pro-fessional below in A and SKIP to D ⇒**IF NO**, GO to B)		(⇒ **IF YES**, GO to C ⇒ **IF NO**, SKIP to next item)		⇒ **IF YES**, Which agency/program/pro-fessional? (list in C1 below) Why did you not get help from this agency/professional? (list in C2 below) GO TO NEXT ITEM ⇒**IF NO**, SKIP to next item		Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
h. Your child's problems learning new things	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
i. Your child's eating problems	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
If child in R HH over 5 j. School attendance	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
If child in R HH over 5 k. Doing homework	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
If child in R HH over 5 l. Academic progress	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
If child in R HH over 10 m. Your child's use of drugs or alcohol	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

[A. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM]

[C1. ENTER AGENCY/PROGRAM/PROFESSIONAL NAME AND LETTER(S) OF ITEM. NOW GO TO C2]

[C2. FOR REASONS WHY HELP NOT RECEIVED, ENTER LETTER OF ITEM AND VERBATIM]

D1. Have you had contact with other agencies or programs that we have not talked about?

YES 1
NO ..... 0 (GO TO E1)

D2. What are their names? <LIST IN TABLE>

Agency and/or program name	How satisfied were you with this agency or program? Very Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
a.	1 ☐	2 ☐	3 ☐	4 ☐
b.	1 ☐	2 ☐	3 ☐	4 ☐
c.	1 ☐	2 ☐	3 ☐	4 ☐
d.	1 ☐	2 ☐	3 ☐	4 ☐
e.	1 ☐	2 ☐	3 ☐	4 ☐

D3. What was the reason for your contact with this agency or program? ENTER LETTER OF ITEM AND VERBATIM]

SECTION E: TYPE OF SUPPORTS

HUSBAND /PARTNER SUPPORT

[SEE A17/A18. IF THE RESPONDENT DOES NOT HAVE A HUSBAND OR PARTNER, GO TO E18.]

E1. Is your [husband/partner] someone you can talk to about problems or things that are very personal or private?

YES 1
NO ..... 0 (GO TO E3)

E2. How often do you talk to your [husband/partner] about problems or things that are very personal or private?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E3. Can you count on your [husband/partner] to help you out with money, food, or clothing?

YES 1
NO ..... 0 (GO TO E5)

E4. How often does your [husband/partner] help you out with money, food, or clothing?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E5. Does your [husband/partner] shop for your family's food or household items?

YES 1
NO ..... 0 (GO TO E7)

E6. How often does your [husband/partner] shop for your family's food or household items?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E7. Does your [husband/partner] help around your house with cleaning or repairs?

YES 1
NO ..... 0 (GO TO E9)
NA, LIVING IN SHELTER ..... 6 (GO TO E9)

E8. How often does your [husband/partner] help around your house with cleaning or repairs?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E9. Does your [husband/partner] help with disciplining your child(ren)?

YES 1
NO ..... 0 (GO TO E11)

E10. How often does your [husband/partner] help with disciplining your child(ren)?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E11. Do you look to your [husband/partner] to give you advice on how to care for your child(ren) or handle household problems?

YES 1
NO ..... 0 (GO TO E13)

E12. How often does your [husband/partner] give you advice on how to care for your child(ren) or handle household problems?

Daily 4
Once to several times a week 3
Once or twice a month 2
At least once a year 1

E13. Do you get other kinds of help from your [husband/partner] ?

YES ..... 1 What kind of help? SPECIFY:

_____

NO ..... 0 (GO TO E15)

E14. How often do you get this other help from your [husband/partner]?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1

E15. Overall, how satisfied are you with the help you get from your [husband/partner] ?

Very satisfied	4
Somewhat satisfied	3
Somewhat dissatisfied	2
Very dissatisfied	1

E16. How often does your [husband/partner] show affection for you?

Often	1
Sometimes	2
Never	3

E17. How often do you and your [husband/partner] argue or fight?

Often	1
Sometimes	2
Never	3

FRIENDS AND FAMILY SUPPORT

Now I have some questions about relatives and friends, other than your husband or partner, who may help with things like babysitting and childcare without pay, loaning you money in an emergency, or just talking over and giving advice on problems.

E18. First, whom do you rely on for any of this or other kinds of unpaid help?

		Yes	No	
a.	Mother/Stepmother	1	0	
b.	Father/Stepfather	1	0	
c.	Grandmother	1	0	
d.	Grandfather	1	0	
e.	Sister(s)	1	0	(IF YES…How many help? _____)
f.	Brother(s)	1	0	(IF YES…How many help? _____)
g.	Aunt(s)	1	0	(IF YES…How many help? _____)
h.	Uncle(s)	1	0	(IF YES…How many help? _____)
i.	Cousin(s)	1	0	(IF YES…How many help? _____)
j.	Grown child(ren)	1	0	(IF YES…How many help? _____)
k.	Mother-in-law	1	0	
l.	Father-in-law	1	0	
m.	Grandmother-in-law	1	0	
n.	Grandfather-in-law	1	0	
o.	Former husband/partner	1	0	
p.	Other relative(s)	1	0	(IF YES…How many help? _____)
q.	Friend(s)	1	0	(IF YES…How many help? _____)
r.	Neighbor(s)	1	0	(IF YES…How many help? _____)
s.	Co-worker(s)	1	0	(IF YES…How many help? _____)
t.	Other(s)	1	0	(IF YES…How many help? _____)
u.	IF R CIRCLES 0 FOR **ALL** OF THE ABOVE CIRCLE 1 (NO ONE) AND GO TO E27 INTRO	1	0	

Now I have questions about the kinds of things these people help you with.

E19. How often do you talk to anyone you listed about problems or things that are very personal or private?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E20. How often does anyone you listed help you out with money, food, or clothing?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E21. How often does anyone you listed help you with work around your house or with caring for your child(ren)?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E22. How often does anyone you listed give you advice on how to care for your child(ren) or handle household problems?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E23. Do you get other kinds of unpaid help from anyone you listed?

YES ..... 1 What kind of help? SPECIFY:

_____

NO ..... 0 (GO TO E25)

E24. How often do you get this other help from anyone you listed?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1

COMMUNITY SUPPORT

E25 INTRO. Parents sometimes rely on people in their community other than relatives and friends for some kinds of help. Now I have some questions about other people in the community who may help out with things like money in an emergency, talking over and giving advice on problems, help with your child(ren), or other kinds of assistance.

E25. I'm going to read a list of people in the community who may help out with these kinds of things and I want you to tell me which ones you go to for help.

		Y	N
a.	Doctor	1	0
b.	Nurse	1	0
c.	Other medical person	1	0
d.	Child(ren)'s school teacher	1	0
e.	School social worker or guidance counselor	1	0
f.	Other school person	1	0
g.	Clergy, minister, priest, rabbi, or someone else from a place of worship	1	0
h.	Child care center teacher, director, or other staff	1	0
i.	Counselor or therapist	1	0
j.	Caseworker	1	0
k.	Family support worker	1	0
l.	Community service organization (YMCA, YWCA, Boys and Girls Club, Scouts)	1	0
m.	Information hotline (211 or parenting hotline)	1	0
n.	Other (SPECIFY _____)	1	0
o.	IF R CIRCLES 0 FOR **ALL** OF THE ABOVE, CIRCLE 1 (NO ONE) AND GO TO E34 INTRO	1	0

E26. How often do any of these people give you advice on how to care for your child(ren) or handle household problems, or how often do you talk to any of them about things that are very personal or private?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E27. How often do any of these people help you out with money, food, or clothing?

Daily	4
Once to several times a week	3
Once or twice a month	2
At least once a year	1
Never	0

E28 INTRO. Now, think about everyone — relatives, friends, spouse or partner, and other people in the community like ministers, teachers, and counselors — who helps you.

E28. Overall, would you say that the amount of help you get is...

Too little	1
Too much	2
About right	3

E29. How easy is it for you to find someone to talk to about problems or things that are very personal or private?

Very hard	1
Somewhat hard	2
Between hard and easy	3
Somewhat easy	4
Very easy	5

E30. How easy is it for you to get help with work around your house or with caring for your child(ren)

Very hard	1
Somewhat hard	2
Between hard and easy	3
Somewhat easy	4
Very easy	5

E31. How easy is it for you to get advice on how to care for your child(ren) or handle household problems?

Very hard	1
Somewhat hard	2
Between hard and easy	3
Somewhat easy	4
Very easy	5

SECTION F: CHILDCARE ARRANGEMENTS

Next, I'd like to talk to you about childcare for your pre-school children (children who have not started elementary school).

F1. Does/Do [TARGET CHILD/YOUR PRESCHOOL CHILDREN] receive care on a regular basis from someone other than you [and your husband/partner]. This includes regular care and early childhood programs, whether or not there is a charge or fee, but not occasional babysitting.

YES	1	
NO	0	(GO TO BOX F11)

F2. CHILD NAME Which of your children are receiving care?	**F3.** CHILDCARE FOR CHILD(REN) Who provides childcare for [CHILD]? (IF 3, 4,5, OR 6, SPECIFY in F3A BELOW.)	**F4.** [IF RELATIVE, FRIEND OR NEIGHBOR] Is this care provided in your home or someplace else?	**F5.** How many days a week does [CHILD] receive care? [Total, from all sources]	**F6.** How many total hours a week does [CHILD] receive care? [Total, from all sources]
LIST CHILDREN'S NAMES BELOW	[ENTER ALL NUMBERS THAT APPLY] RELATIVE (1), FRIEND OR NEIGHBOR (2), CHILDCARE CTR OR HEAD START CTR (3), PRE-KINDERGARTEN CENTER AT A SCHOOL (4), FAMILY CHILD CARE (5), SOMEONE ELSE (SPECIFY) (6)	[ENTER ALL THAT APPLY] HOME (1), SOMEPLACE ELSE (2)	[ENTER NUMBER OF DAYS A WEEK]	[ENTER TOTAL WEEKLY HOURS]
(01)				
(02)				
(03)				
(04)				
(05)				
(06)				

F3A. IF F3 = 3, 4, 5, OR 6, ASK What is the name of the center or program where your [CHILD/CHILDREN] receive care?

F7. Do you pay for childcare [for any of your children]?

YES 1
NO ..... 0 **(GO TO F9)**

F8. What is the total amount you pay for child care for [TARGET CHILD/YOUR CHILDREN]? [GET AMOUNT AND SPECIFY TIME PERIOD: WEEKLY, MONTHLY, YEARLY, OTHER.] (CIRCLE ONE).

___ ___ ___ ___.**00**

WEEKLY
MONTHLY
YEARLY
OTHER

F9. Do any of the following people or organizations help to pay for [TARGET CHILD/YOUR CHILDREN]'s child care? How about..

		Yes	No
a.	A relative outside your household who provides money specifically for that care?	1	0
b.	Family Central (subsidy from the state)	1	0
c.	Another social service or welfare agency?	1	0
d.	An employer?	1	0
e.	Someone else?	1	0

F10. Overall, how satisfied are you with your childcare arrangements?

Very satisfied 1
Somewhat satisfied 2
Somewhat dissatisfied 3
Very dissatisfied 4

BOX F11

REFER TO THE HHE TABLE TO SEE IF RESPONDENT LISTED HER CHILD(REN) IN SCHOOL 28(i). IF NO CHILD(REN) IN SCHOOL GO TO G1.

F11. During the school year, do any of your school-age children receive care from someone other than you on a regular basis or go to any organized programs or activities after school or on the weekends?

YES 1
NO ..... 0 (GO TO F16)

[ENTER THE FOLLOWING INFORMATION FOR EACH CHILD IN TABLE BELOW]

F12. CHILD NAME Which of your children are in an after-school activity or program?	**F13.** I will list some activities that happen in after-school programs. Tell me whether the program [CHILD] is in has these activities.	**F14.** How many days a week does [CHILD] go to this program?	**F15.** How many hours a week does [CHILD] spend in this program?
LIST CHILDREN'S NAMES BELOW and SPECIFY NAME OF PROGRAM BELOW in F12A	[ENTER NUMBERS FOR ALL THAT APPLY] Sports (1), Arts or crafts (2), A program to help him/her in school (3), Recreational (4), Child care (5), Other (6)	[ENTER NUMBER OF DAYS A WEEK]	[ENTER TOTAL WEEKLY HOURS]
(01)			
(02)			
(03)			
(04)			
(05)			
(06)			

F12A. What is the name of the center, school, or program where your [CHILD/CHILDREN] take part in after-school activities or receive after-school care?

F16. Do you pay for after-school activities for your children?

YES 1
NO 0

F17. Would you say the opportunities for after-school activities for your children are…

Adequate or 1
Not adequate 2

F18. How satisfied are you with your child[ren]'s after school arrangements?

Very satisfied 1
Somewhat satisfied 2
Somewhat dissatisfied 3
Very dissatisfied 4

F19. During the summer, do any of your children receive care from someone other than you on a regular basis or go to any organized programs or activities?

YES 1
NO 0

F20. Would you say the opportunities for summer activities for your children are…

Adequate or 1
Not adequate 2

F21. How satisfied are you with your child[ren]'s summer arrangements?

Very satisfied 1
Somewhat satisfied 2
Somewhat dissatisfied 3
Very dissatisfied 4

SECTION G: CARING FOR CHILDREN

The next questions are about caring for child(ren). The questions ask what you [and/or your partner/husband] do with your child(ren).

G1. IF R HAS PARTNER/HUSBAND BUT HE IS NOT LIVING IN THE HOME ASK:
Has your [husband/partner] had contact with any of your child(ren) in the last 3 months?

YES 1
NO 0

[(a) ASK RESPONDENT QUESTION FIRST; (b) THEN READ ACROSS AND ASK THE SAME QUESTION ABOUT THE HUSBAND/PARTNER. IF R HAS NO HUSBAND/PARTNER OR HE HAS NOT HAD CONTACT WITH CHILDREN IN PAST 3 MONTHS, SKIP QUESTIONS ABOUT HUSBAND/PARTNER; (c) THEN ASK QUESTION ABOUT HOW OFTEN EITHER PARENT DOES ACTIVITY.]

In the past 3 months…	**G1.**		**G2. How about your [husband/partner] ?**		**G3. If YES TO EITHER G1 or G2, ASK: how often do you [and/or your partner/ husband] do this?**		
	YES	**NO**	**YES**	**NO**	**Daily or most days**	**At least once a week**	**Once or twice a month**
a. Have you read or looked at books with your child(ren)?	1	0	1	0	1	2	3
b. Have you told stories to your child(ren)?	1	0	1	0	1	2	3
c. Have you sang songs with your child(ren)?	1	0	1	0	1	2	3
d. Have you taken your child(ren) along while doing errands like going to the post office, the bank, or the store?	1	0	1	0	1	2	3
e. Have you taken your child(ren)outside for a walk or to play in the yard, a park, or a playground?	1	0	1	0	1	2	3
f. Have you played with clay, drawn pictures, or done other arts and crafts with your child(ren)?	1	0	1	0	1	2	3
g. Have you played a game, done a puzzle, or made something with a building toy with your child(ren)?	1	0	1	0	1	2	3
h. Have you visited the library with your child(ren)?	1	0	1	0	1	2	3
i. Have you done household chores, e.g., clean or cook, with your child(ren)?	1	0	1	0	1	2	3
j. Have you sometimes lost your temper when your child(ren) got on your nerves?	1	0	1	0	1	2	3

In the past 3 months…	**G1**		**G2. How about your [husband/partner] ?**		**G3. If YES TO EITHER G1 or G2, ASK: how often do you [and/or your partner/ husband] do this?**		
	YES	**NO**	**YES**	**NO**	**Daily or most days**	**At least once a week**	**Once or twice a month**
k. Have you sometimes found that hitting or spanking your child(ren) was a good way to get your child(ren) to listen?	1	0	1	0	1	2	3
l. Have you sometimes found yourself getting more angry than you mean to with your child(ren)?	1	0	1	0	1	2	3
m. Have you praised your child(ren), e.g., said "good job" when your child(ren) finished eating or picked up toys?	1	0	1	0	1	2	3
n. Have you encouraged your child(ren) to read a book?	1	0	1	0	1	2	3
o. Have you punished your child(ren) for not finishing the food on (his/her/their) plate(s)?	1	0	1	0	1	2	3
p. Have you sometimes blamed your child(ren) for things that you realized were not really your child's(ren's) fault?	1	0	1	0	1	2	3
q. Have you talked about a television program with your child?	1	0	1	0	1	2	3
[ASK ONLY FOR CHILD(REN) IN CHILD CARE OR SCHOOL] [SEE F1 and F11]	1	0	1	0	1	2	3
r. Have you helped your child(ren) with homework?	1	0	1	0	1	2	3
s. Have you attended a parent-teacher conference about your child(ren)?	1	0	1	0	1	2	3
t. Have you talked with your child's teacher or caregiver about his/her progress at any other time?	1	0	1	0	1	2	3
u. Have you attended a field trip or a family event, e.g., an open house, at your child's center or school?	1	0	1	0	1	2	3
v. Have you attended a PTA or other parent meeting at your child's center or school?	1	0	1	0	1	2	3

G4. Some people attend religious services more often than others and some never attend. How often did you attend religious services in the past year? Was it…

Never 0
About once or twice 1
Several times during the year..... 2
About once or twice a month, or 3
Nearly every week or more 4

SECTION P: YOUR FEELINGS

BOX P

HAND PAGES TITLED "*SECTION P: YOUR FEELINGS*" TO RESPONDENT.

SAY: You can answer these next questions about your feelings on your own or I can read them to you. Would you like me to read them to you or would you prefer to read them to yourself? I am going to have you mark your answers on this sheet by circling the number. [INTERVIEWER CIRCLE 1 OR 2.]

QUESTIONS READ TO RESPONDENT..... 1
RESPONDENT READ QUESTIONS..... 2

[Parenting Stress Inventory (PSI) (Psychological Assessment Resources, Inc.)]

P INTRO: I am going to read a list of feelings and thoughts you may have had. Please circle how much you agree or disagree with these feelings. You can answer strongly agree, agree, not sure, disagree, or strongly disagree.

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
P1.	I often have the feeling that I cannot handle things very well.	1	2	3	4	5
P2.	I find myself giving up more of my life to meet my children's needs than I ever expected	1	2	3	4	5
P3.	I feel trapped by my responsibilities as a parent.	1	2	3	4	5
P4.	Since having this child, I have been unable to do new and different things.	1	2	3	4	5
P5.	Since having a child, I feel that I am almost never able to do things that I like to do.	1	2	3	4	5
P6.	I am unhappy with the last purchase of clothing I made for myself.	1	2	3	4	5
P7.	There are quite a few things that bother me about my life.	1	2	3	4	5
P8.	Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).	1	2	3	4	5
P9.	I feel alone and without friends.	1	2	3	4	5
P10.	When I go to a party, I usually expect not to enjoy myself.	1	2	3	4	5
P11.	I am not as interested in people as I used to be.	1	2	3	4	5
P12.	I don't enjoy things as I used to.	1	2	3	4	5
P13.	My child rarely does things for me that make me feel good.	1	2	3	4	5
P14.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	1	2	3	4	5
P15.	My child smiles at me much less than I expected.	1	2	3	4	5
P16.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	1	2	3	4	5
P17.	When playing, my child doesn't often giggle or laugh.	1	2	3	4	5
P18.	My child doesn't seem to learn as quickly as most children.	1	2	3	4	5

Adapted and reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, from the Parenting Stress Index Short Form by Richard R. Abidin, Ed.D., Copyright 1990, 1995 by PAR, Inc. Further reproduction is prohibited without permission from PAR, Inc.

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
P19.	My child doesn't seem to smile as much as most children.	1	2	3	4	5
P20.	My child is not able to do as much as I expected.	1	2	3	4	5
P21.	It takes a long time and it is very hard for my child to get used to new things.	1	2	3	4	5
For the next statement, choose your response from the choices "1" to "5" below.						
P22.	I feel that I am: 1. not very good at being a parent. 2. a person who has some trouble being a parent. 3. an average parent. 4. a better than average parent. 5. a very good parent.	1	2	3	4	5
P23.	I expected to have closer and warmer feelings for my child than I do and this bothers me.	1	2	3	4	5
P24.	Sometimes my child does things that bother me just to be mean.	1	2	3	4	5
P25.	My child seems to cry or fuss more often than most children.	1	2	3	4	5
P26.	My child generally wakes up in a bad mood.	1	2	3	4	5
P27.	I feel that my child is very moody and easily upset.	1	2	3	4	5
P28.	My child does a few things which bother me a great deal.	1	2	3	4	5
P29.	My child reacts very strongly when something happens that my child doesn't like.	1	2	3	4	5
P30.	My child gets upset easily over the smallest thing.	1	2	3	4	5
P31.	My child's sleeping or eating schedule was much harder to establish than I expected.	1	2	3	4	5

For the next statement, choose your response from the choices "1" to "5" below.						
P32.	I have found that getting my child to do something or stop doing something is: 1. much harder than I expected. 2. somewhat harder than I expected. 3. about as hard as I expected. 4. somewhat easier than I expected. 5. much easier than I expected.	1	2	3	4	5
For the next statement, choose your response from the choices "10+" to "1-3."						
P33.	Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.	10+	8-9	6-7	4-5	1-3

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
P34.	There are some things my child does that really bother me a lot.					
P35.	My child turned out to be more of a problem than I had expected.					
P36.	My child makes more demands on me than most children.					

Adapted and reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, from the Parenting Stress Index Short Form by Richard R. Abidin, Ed.D., Copyright 1990, 1995 by PAR, Inc. Further reproduction is prohibited without permission from PAR, Inc.

SECTION H: ALCOHOL USAGE AND SMOKING

Some people drink alcohol and some do not.

H1. Do you currently drink any alcoholic beverages?

YES	1	
NO	0	(GO TO H4)

H2. How many alcoholic drinks do you have in an average week now?

LESS THAN 1	1
1 TO 3	2
4 TO 6	3
7 TO 13	4
14 TO 19	5
20 OR MORE	6

H3. In the last month, how many times did you drink four or more alcoholic drinks at one time? [IF RESPONDENT DID NOT HAVE 4 OR MORE DRINKS AT ONE TIME, ENTER 00.]

[IF RESPONDENT CAN'T REMEMBER, PROBE FOR BEST GUESS]

|___|___|
TIMES

H4. Do you currently smoke?

YES	1	
NO	0	(GO TO I1)

H5. How many cigarettes do you smoke in an average day now? (A pack has 20 cigarettes.)

LESS THAN 1	1
1 TO 5	2
6 TO 10	3
11 TO 20	4
21 TO 40	5
41 OR MORE	6

SECTION I: USE OF PUBLIC FINANCIAL SUPPORTS

Now I have some questions about your household.

I1. In the last year have you or someone else in your household…

		YES	NO
a.	Received food stamps?	1	0
b.	Been in WIC, the Women Infants and Children Supplemental Food Program?	1	0
c.	Gotten checks from TANF or welfare?	1	0
d.	Had help with your rent from a voucher program?	1	0
e.	Received Social Security disability checks, that is, SSI?	1	0
f.	Received Unemployment Insurance (UI) benefits	1	0
g.	Received the Earned Income Tax Credit (EITC)	1	0

I2. Please look at this card and tell me which of these amounts comes closest to your total household income from all sources for [LAST CALENDAR YEAR, e.g. 2005, 2006]. You can just tell me the letter.

[HAND RESPONSE CARD TO MOTHER]

A.	LESS THAN $ 1,000	01
B.	$1,000 - $2,499	02
C.	$ 2,500 - $4,999	03
D.	$ 5,000 - $9,999	04
E.	$10,000 - $19,999	05
F.	$ 20,000 - $39,999	06
G.	$40,000 - $59,999	07
H.	$60,000 - $74,999	08
I.	$ 75,000 - $99,999	09
J.	$100,000 or more	10

SECTION J: YOUR FEELINGS

BOX J1

HAND PAGES TITLED "*SECTION J: YOUR FEELINGS*" TO RESPONDENT.

SAY: We often read these next questions to respondents, would you like me to read them to you or would you prefer to read them to yourself? I am going to have you mark your answers on this sheet by circling the number. [INTERVIEWER CIRCLE 1 OR 2.]

QUESTIONS READ TO RESPONDENT..... 1
RESPONDENT READ QUESTIONS..... 2

J1 INTRO: **I am going to read a list of ways you may have felt. Please circle how often you have felt this way during the past week: rarely or none of the time, that is, less than 1 day; some or a little of the time, 1 or 2 days; occasionally or a moderate amount of the time, 3 or 4 days; or most or all of the time, 5 to 7 days.**

During the past week…	0 Rarely or none of the time (less than 1 day)	1 Some or little of the time (1-2 days)	2 Occasionally or a moderate amount of the time (3-4 days)	3 Most or all of the time (5-7 days)
J1. You were bothered by things that usually don't bother you.	0	1	2	3
J2. You did not feel like eating; your appetite was poor.	0	1	2	3
J3. You felt that you could not shake off the blues even with help from family or friends.	0	1	2	3
J4. You felt that you were just as good as other people.	0	1	2	3
J5. You had trouble keeping your mind on what you were doing.	0	1	2	3
J6. You felt depressed.	0	1	2	3
J7. You felt that everything you did was an effort.	0	1	2	3
J8. You felt hopeful about the future.	0	1	2	3
J9. You thought your life had been a failure.	0	1	2	3
J10. You felt fearful.	0	1	2	3
J11. Your sleep was restless.	0	1	2	3
J12. You were happy.	0	1	2	3
J13. You talked less than usual.	0	1	2	3
J14. You felt lonely.	0	1	2	3
J15. People were unfriendly.	0	1	2	3
J16. You enjoyed life.	0	1	2	3
J17. You had crying spells.	0	1	2	3
J18. You felt sad.	0	1	2	3
J19. You felt that people disliked you.	0	1	2	3
J20. You could not get "going."	0	1	2	3

RECORD END TIME: |___|___|:|___|___|
[GET CONTACT INFORMATION FOR SECTION K]

CASE ID:_____

SECTION K: CONTACT INFORMATION

Because we want to contact you again in about 6 months, I would like to get some information from you that will help us locate you in case you move.

[IF R IS NOT WORKING, WRITE NA FOR K1, K2, K3]

K1. What is the name of your workplace? _____

K2. Your workplace address: _____

K3. Your work phone number: _____

K4. Your home phone number: _____

K5. Your cell phone number: _____

K6 Will you please tell me the name, address and telephone numbers of three individuals who will always know where you are or how to reach you. We will only contact these individuals if we are unable to locate you at your current address or telephone number. Anyone we contact will be asked only if they know how to reach you. They won't be given any information, and they won't be interviewed.

Name	Address	Home Telephone Number	Cell or Work Telephone Number	Relationship to you (e.g., family, friend, co-worker, etc.)

See B8. IF MOTHER SAYS YES, SHE HAS IMMUNIZATION RECORDS FOR [TARGET CHILD] ASK MOTHER IF SHE CAN FIND THEM NOW. IF RECORDS ARE AVAILABLE AND MOTHER IS WILLING TO SHARE INFORMATION, FILL IN THE FOLLOWING TABLE. DO NOT ASK MOTHER FOR THIS INFORMATION OR RELY ON HER MEMORY.

MOTHER AGREES TO SHARE INFORMATION..... 1
MOTHER DECLINES TO SHARE INFORMATION..... 0

	YES	(# Doses)	NO	Not Indicated
DPT: Diphtheria, Tetanus, Pertussis (Whooping Cough)	1	( )	2	9
Polio	1	( )	2	9
Hepatitis B	1	( )	2	9
Varicella (Chicken pox)	1	( )	2	9
MMR: Measles, Mumps, Rubella	1	( )	2	9
Influenza Type B	1	( )	2	9

[PROVIDE R WITH $ 25.00 CASH INCENTIVE]

That is all. Thank you very much for helping us with our study. I look forward to talking with you again in 6 months.

INTERVIEWER COMMENTS

PLEASE NOTE ANY ISSUES OR CONCERNS THAT CAME UP DURING THE INTERVIEW (SUCH AS FREQUENT INTERRUPTIONS, PRESENCE OF OTHER FAMILY MEMBERS DURING THE INTERVIEW, CONCERNS ABOUT THE LENGTH OF THE INTERVIEW, OR DIFFICULTIES WITH PARTICULAR QUESTIONS OR SECTIONS).

_____

_____

_____

_____

_____

THE PALM BEACH COUNTY QUALITATIVE STUDY
INTERVIEW GUIDE: MAJOR TOPICS AND THEMES

Daily Routine and Household Information (Domestic Workload and Childcare Tasks)

This area covers the daily routine of the mother and target child, the complexity of the family's domestic workloads (e.g., cooking, cleaning, shopping, running errands), and the level of assistance available inside and outside the family. This dimension also covers the complexity of the family's childcare situation, roles, and responsibilities. Who does childcare, how is it organized, and how is it balanced with other domestic demand?

Social Support and Connectedness

This dimension covers the mothers' connectedness to members of her extended family, their involvement with her children, and the structure and quality of family relationships. This dimension covers the mother's formal and informal social support networks (e.g. friends, church) for sources of information, instrumental assistance, emotional support, and companionship. This dimension also includes **the role of men**, i.e., the role of fathers, male partners, and other men outside the immediate family, and **the role of grandparents**, in the lives of mothers and their children. It also covers the role of religion in their daily lives.

Educational and Child Care Experiences

This dimension covers family's involvement and communication with childcare centers, pre-schools, or school to support the educational needs of child. It also includes parents' satisfaction with their current childcare, pre-school, or school arrangement(s).

Income, Work, and Economic Supports

This dimension covers the family's available income and occupational status as well as the family's attitudes about her work. It includes themes such as security, stability, flexibility, insurance, wealth, equity back-ups, and reliance on multiple sources of financial support. (Examples: Paycheck or money from a job, Money from family or friends, Money from a business, fees, dividends, or rental income, aid such as Temporary Assistance for Needy Families (TANF), welfare, WIC, public assistance, general assistance, food stamps, or Supplemental Security Income; Unemployment benefits; Child support or alimony; Social security, workers' compensation, disability, veteran benefits, or pensions.)

Health Care and Social Services

This dimension covers the number and kinds of social services used by the mother, infant and other family members. Services could include welfare, health services, and other community and government services.

Mobility and Neighborhood Characteristics

This dimension covers changes in the location of the home, the safety of the neighborhood, and opportunities for children.

Cultural Influences, Religion, Language, and Experiences of Discrimination

This dimension covers cultural and religious beliefs and influences in the family and community, in relation to parenting practices, child care, education, and use of services. It also covers experiences of discrimination and barriers to services because of language.

Daily Routine/ Household Information

In this section, we want to get a picture of what a mother's typical day is like. We want to find out how she manages the tasks of childcare and housework, and who, if anyone, helps her—e.g., spouse/partner, older children, other family members, friends, or neighbors. In this regard, we are interested in what household or child care tasks are expected of older children as well as gender roles in these areas. Mothers may talk about playing or doing different activities with their children, getting them ready for school or childcare, taking them to school or childcare, going on errands, going to work, school, or a job training program, picking them up from school or childcare, making dinner, getting the children ready for bed, etc. We also want to find out how mothers re-arrange their schedules if they or their children are sick, and how household tasks and child care on weekends differ from week days.

To start, I would like to know a little bit about who lives in your house. I know you have one child living with you, [target child's name]. Who else lives in your house and what is their age and relation to you?

(A typical day)
Can you take me through a typical day for you and your child(ren) from when you get up till when you go to bed?

(Help with household tasks and child care)
Does anyone help you take care of your children? *(Probe for family or friends.)*

Does anyone help you with the housework? *(Probe for family or friends.)*

If mother has older children and has not mentioned their role, ask:
Does/do [names of the children] help you take care of the younger children?

If mother has a 2nd caregiver: After mother describes housework and childcare distribution with 2nd caregiver, ask:
How satisfied are you with this? (probes: Is that a good balance for you? Would you change this in any way?)

(Unusual circumstances)
What happens if your child(ren) is sick?

What happens if you are sick?

How are the weekends different than the week?
[Mothers may mention going to church, to family gatherings, to friends' house, to a movie theater with children, for an ice-cream]

(Informal support)
Is there any other way that family or friends help you?

[*In this question we want to find out about mother's informal social support, including emotional support (examples might be a friend/relative drives mom to doctor's appointment or Respondent talks to partner/mother/friend about her problems*)]

Parental Beliefs, Goals, and Practices about Child Care and Child Development

In this section we want to learn about mothers' beliefs, values, and practices about raising children. We want to learn where mothers get information or advice about taking care of their child(ren), what sources they feel are most helpful, what types of information they get from these sources, and how easy or difficult it is to find information. We also want to learn what activities they like to do with their children, what they expect their preschool-age children to be able to do, what goals they have for their children, their beliefs about racism and discrimination in raising their children, and how their parenting is affected by their culture, religion, or family traditions.

What is the best thing about being a parent?

What is the hardest thing about being a parent?

Where do you get information or advice about taking care of your child(ren)?
[Mothers may mention informational sources such as family members, spouse/partner, friends, teachers, childcare providers, doctors, other healthcare professionals, themselves/their personal beliefs, and co-workers.]

What sources are most helpful?

What kind of information or advice do you get from these (your most helpful) sources?
[Mothers may mention topics such as feeding, toilet training, and discipline.]

Is it difficult to find information when you want it?

What kind of activities do you enjoy doing with your child (ren)?

(Expectations)
Parents often have things they expect their children to do at certain ages. What do you hope [target child] will be like or be able to do when he/she is 3 years old? What about when he/she starts kindergarten (around 5 or 6 years old)?

What about when he/she is 18 years old? What do you expect or hope? (Or, what would you like him/her to be when grown up?)

(Racism/discrimination)
Some parents feel that racism and discrimination are important things to be concerned with when raising their child(ren) and some do not. What would you say?

Have you or your family ever experienced discrimination? If yes, could you describe the situation?

Some parents feel their heritage is important in raising children. What do you think?
Is there anything you do in raising your children that comes from your heritage? Are there things you do that are the same? Are there things you do that are different? *(Food or cooking might be an example. Religion is another example.)*

Educational and Childcare Experience

In this section, we want to learn about mothers' involvement and communication with childcare centers, pre-schools, or schools to support the educational needs of child. We want to learn about their satisfaction and their child(ren)'s satisfaction with their current childcare, pre-school, or school arrangement(s). We also want to learn about mothers' beliefs about school readiness and school success—how they prepare their children to enter kindergarten and what they think is important in helping their children succeed in school. For mothers whose first language is not English, we want to learn about any language barriers they may encounter in communicating with their child(ren)'s preschool caregiver or school teacher. Ask these questions about the target child and if applicable, about one other child in pre-school or school. If target child is not in childcare/pre-school, ask about two children in pre-school or school, if applicable. Ask the series of questions separately for each child's situation (preschool/childcare or school).

Does your child(ren) like going to childcare/school?

What are some of the things that you like about your child(ren)'s childcare/school?

What are some of the things that you wish you could change about your child(ren)'s childcare/school? [*Mothers who do not speak English as their first language may discuss language barriers.]*

How often do you communicate with your child(ren)'s childcare center and/or school?
Mothers may mention parent-teacher conferences, informal conversations with teachers, open houses, telephone calls with teachers, volunteering in the classroom, or attending services with their child(ren) at school.

What do you communicate about?

Is it easy to communicate with your child(ren)'s childcare center and/or school?
Mothers who do not speak English as their first language may discuss language barriers.

What is important for your child(ren)'s caregiver/teacher to know about your children and your family?

Have you had a chance to communicate this information yet?

Some parents think that it is important to do certain activities with their children to get them ready to start kindergarten. What about you?
Mothers may mention having their children know their name, address, and phone number or reading with their children, speaking English, etc.

If mother has children in preschool or school, ask: Some parents think that it is important to do certain activities with their children to help them do well in preschool or school. What about you? *Mothers may mention helping child with schoolwork, playing with child, reading with child, communicating with teachers at school, etc.*

How do you know how your child in doing is school? Probes: Do you understand your child's report card or other reports from his or her teacher? What do you do if you are not able to understand the school's reports?

Income, Work, and Economic Supports

In this section, we want to learn about mothers' attitudes towards income and work, economic resources available, economic security and stability, economic resources needed, experiences using income support programs, and how mothers pay for their child(ren)'s childcare, pre-school, or school.

Are you employed or in school?

If yes, ask: What is that like? Do you enjoy your work/school? *(Probe to find out how many hours mother works and/or attends school and the nature of her job or school course, e.g., whether her schedule is flexible or whether her job is secure.)*

It can be hard to work when you have children. How it is for you?

Have you ever changed jobs, taken a job, or not taken a job because of your child(ren)?

How do you make ends meet? What sources of income do you have to take care of your family's needs? Probes: What financial supports do you use? Does anyone help you out?
Mothers may mention loans from family or friends, savings account, SSI, unemployment insurance, food stamps, WIC, rent vouchers, checks for TANF/welfare, Earned Income Tax Credit (EITC).

Do you feel like you have enough to meet your family's basic needs?

Do you, or have you ever used food stamps or WIC?
If yes, ask: What has your experience been?

If no, ask: Is there any reason why?

If family uses any public income supports other than food stamps or WIC, ask: Tell me about your experience using [income support]. [*In this question, we want to learn where mothers found out about the income support, how easy or difficult it was to access it, and how easy or difficult it has been to keep using it.]*

How would you handle an unexpected expense like a medical bill or car repair?

Do you provide for family living outside of your home or in another country?

If child(ren) in childcare, pre-school, or school, ask: Do you pay for childcare or school? If yes, ask: How do you pay for it? (Or, how does childcare/school fit into your budget?)

Do you know of any places you can get financial help with childcare/school?

Health Care and Social Services

In this section, we want to learn about the services mothers and their families currently use or have used in the past year; their perceived usefulness of services; how they get information about services; how easy or difficult is it for them to get information about services; how easy or difficult is it for them to gain access to services; their concerns or perceived need of services; their knowledge of services available to them; and how they pay for services or obtain insurance coverage. We are also interested in any previous experiences with services (in the US or another country) that might affect their current use of services. For mothers whose first language is not English, we want to learn about any language barriers they may encounter when accessing or using services.

Let's talk a little about services for you and your family. By "services," I mean health care services like doctor and dentist visits, counseling, family support, and parenting classes. (Other examples might be child care, speech therapy, help with housing, food, or clothing—if mother did not mention them earlier.)

(Use):
What kinds of social services or health care services do you or your family use?

What kinds of social services or health care services did you or your family use in the past year?
Mothers may mention counseling, pre-natal care, well-baby care, emergency care, acupuncture, dentist, etc.

(Usefulness):
Please tell me about your experiences with these services.

How did they help?

What could have made them more helpful?

Would you use them if you needed them again in the future?

(Accessing):
How did you find out about these services?

Were you referred to these services or did you seek them on your own?

How easy or difficult was it to find them?

How easy or difficult is it to access these services?
Mothers may mention transportation, childcare, language, etc.

For mothers whose first language is not English, ask: Was language a problem for you?

Has there ever been a time where you or your family have not been able to access services because of fear of discrimination? If yes, ask:

Could you describe the situation?

How did you feel?

(Needs):
Do you or any of your children have special physical or emotional health needs? If yes, ask: What needs?

Do you currently have any concerns about the physical or emotional health of you or your children?

Do you plan to seek help?

Is there anything keeping you from getting help?
Mothers may mention cost, transportation, childcare, wait list, awareness, immigration status, etc.

Did you have any concerns in the past year that you didn't seek help for? If yes, ask:

What were they?

Can you tell me why you didn't seek help?

Did you have any concerns in the past year for which you sought help but didn't receive it?

If yes, ask: Please tell me about those experiences.

(Affordability):
Do you have health care coverage?

If no ask: How do you handle medical needs and decisions?

If yes, ask: What does it cover (e.g. drug prescriptions, medical equipment, co-pays).

Can you afford these services?

Mobility and Neighborhood Characteristics

In this section, we want to learn about mothers' mobility and their perceptions of their neighborhood, particularly in regards to raising children, e.g., whether or not it is safe and whether it provides opportunities like recreation and after-school programs for children. We are also interested in learning about what informal and community supports, including faith-based ones, that are available to and used by families.

How long have you lived in this community?

How long have you lived in Palm Beach County?

How long have you lived in the United States?

If mother not born in the United States, ask: What country are you from?

Do you have any plans to move soon?
If yes, ask: Why?

Thinking about raising your children, what is your neighborhood like?

What is available in your neighborhood to help parents raise their children?

What do you use?
[Examples: YMCA, community center, church]

Do you have family or friends who live in your neighborhood? *[Ask only if you do not think you have enough information about informal social support.]*

How would you change your neighborhood to make it a better place to raise children?

Ending the Interview

Is there anything else that you would like to tell me [or that you think I should know) that we haven't already talked about?
If I think If anything else can I call you?
[Review main topic areas of interview if there is time and it seems appropriate.]

APPENDIX B

Sample Characteristics by Maternal Nativity

Table B-1. Selected Characteristics of Mothers by Maternal Nativity and Recency of Immigration[a]

Characteristic at Year 3	All Mothers (*N*=390)	Born in the US (*n*=166)	Foreign-born ≥ 5 years in US (*n*=151)	Foreign-born < 5 years in US (*n*=73)
TGA (%)* **				
Glades	12	22	6	3
Non-Glades	78	66	87	86
Outside TGAs	10	12	7	11
Initial risk/service need status (%)				
At risk/high need	31	33	26	38
Mother's race (%)* **				
Hispanic	54	20	74	90
Black, not Hispanic	38	63	23	10
White, etc.	8	17	3	0
Mother's education (%)* **				
High school/GED	22	31	17	10
Marital status (%)* **				
Married, living with husband	30	18	38	43
Single[a], living with a partner	33	22	40	43
Single, in a relationship but not living with partner	10	21	3	1
Single, not in a relationship	26	39	18	14
Number of children (%) **				
One	33	31	26	50
Two	34	36	34	32
Three or more	33	33	40	18
Employment (%)				
Mother currently working	49	55	47	41
Husband/partner working*	89	82	93	94
Main language spoken in home (%)* **				
English	45	90	17	3
Spanish	48	9	72	89
Other	7	1	12	8
Household income in previous year (%) **				
Less than $20,000	50	49	42	67
$20,000 or more	50	51	58	33
Income-to-Need Ratio (%) **				
Living at or below poverty threshold	54	52	48	72
Living conditions (%)				
Own home*	24	29	25	11

[a] Data were weighted to adjust for the over sampling of mothers in the Glades and mothers screened "at risk."

[b] Single includes respondents who identified themselves as single, never married; divorced; separated; or widowed.

Chi-square analysis indicated that differences in characteristics associated with native-born and foreign-born mothers are statistically significant at *$p \leq .05$, ** $p \leq .01$, or *** $p \leq .001$

Table B-2. Selected Health Characteristics of Mothers by Maternal Nativity and Recency of Immigration[a]

Characteristic at Year 3	All Mothers (*N*=390)	Born in the US (*n*=166)	Foreign-born ≥ 5 years in US (*n*=151)	Foreign-born < 5 years in US (*n*=73)
Health Insurance				
Mother covered***	39	72	17	10
All or some children covered**	81	88	76	74
Health Status				
Mother's health good/very good/excellent	85	89	84	77
Baby's health good/very good/excellent*	93	97	91	86
Baby has special medical needs*	18	25	13	14
One or more well-baby check-ups	90	93	85	92
Maternal Depression				
CES-D score ≥16	18	16	21	17

Chi-square analysis indicated differences between the three groups of mothers are statistically significant at *$p < .05$, ** $p < .01$, or *** $p < .001$.

Table B-3. Services, Economic Supports, and Social Support by Maternal Nativity and Recency of Immigration[a]

Characteristic at Year 3	All Mothers (*N*=390)	Born in the US (*n*=166)	Foreign-born ≥ 5 years in US (*n*=152)	Foreign-born < 5 years in US (*n*=72)
Income Supports				
WIC***	60	46	68	77
Food stamps***	34	47	20	31
Earned Income Tax Credit***	18	27	14	8
SSI (Social Security Disability)***	8	16	2	3
TANF	3	6	1	1
Rent voucher***	4	10	0	0
Unemployment insurance	1	2	0	0
Attendance at Religious Services				
Once a month or more often	51	53	48	52
Use of Formal Services (All Y3 items)				
5 or more*	18	26	11	14
Use of Formal Services (Consistent items)				
5 or more***	11	20	4	6
Child Care				
Preschool child in child care***	56	69	49	40
Child care subsidy from Family Central**	30	39	24	11

Chi-square analysis indicated differences between the three groups of mothers are statistically significant at *$p < .05$, ** $p < .01$, or *** $p < .001$.

Table B-4. Social Support by Maternal Nativity and Recency of Immigration[a]

Social support	All Mothers (*N*=390) Mean (*SD*)	Born in the US (*n*=166) Mean (*SD*)	Foreign-born ≥ 5 years in US (*n*=152) Mean (*SD*)	Foreign-born < 5 years in US (*n*=73) Mean (*SD*)
Frequency of support from…				
Husband/partner (scale range: 0-20)[a]	11.3 (*3.4*)	11.3 (*3.6*)	11.3 (*3.4*)	11.4 (*2.8*)
Family/friend (scale range: 0-29)***	5.0 (*4.4*)	6.8 (*5.5*)	4.0 (*2.8*)	3.3 (*2.7*)
Someone else in community (scale range: 0-9)	1.1 (*1.5*)	1.3 (*1.7*)	1.0 (*1.3*)	1.0 (*1.6*)
Access to support				
Ease of getting support (scale range: 1-5)***	3.8 (*1.1*)	4.3 (*0.9*)	3.5 (*1.1*)	3.3 (*1.1*)

[a] Husband/partner *n*=287 (100 of mothers born in the US, 187 of mothers who were foreign-born)

Table B-5. Types of Preschool Child Care Arrangements FOR ALL CHILDREN by Maternal Nativity[a] –

Type of Care Provider	All Mothers (*N*=218)	Born in the US (*n*=114)	Foreign-born ≥ 5 years in US (*n*=75)	Foreign-born < 5 years in US (*n*=29)
Relative	34	40	28	24
Child care center/Head Start/ Pre-K*	43	42	51	24
Friend/neighbor ***	19	9	23	54
Family child care***	13	24	1	3
Other (not specified)	1	0	1	3

[a] Percentages are based on the frequencies of mothers mentioning for each category. The 218 mothers represent 308 children; fourteen mothers reported using more than one child care arrangement for one or more of their children.

The total number of children in childcare in year 3 remained the same at 308. Comparing the respondents who reported that they had at least one child in childcare at Year 2 to those who reported having at least one child in childcare at Year 3, we found that 156 of the 390 respondents had a child(ren) in childcare at both time points. Of the 390 respondents, 131 did not have any children in childcare at Year 2 or at Year 3. There were 62 respondents who began childcare in Year 3 after not reporting any childcare use in Year 2 and an additional 42 respondents who used childcare in Year 2, but not in Year 3.

Table B-6. Types of Preschool Child Care Arrangements FOR TARGET CHILD by Maternal Nativity[a]

Type of Care Provider	All Mothers (*N*=205)	Born in the US (*n*=113)	Foreign-born (*n*=92)
Relative	29	33	25
Child care center/Head Start	32	32	33
School-based Pre-K	1	1	0
Friend/neighbor ***	19	7	34
Family child care***	12	20	1
Other (not specified)	1	0	1

[a] Percentages are based on the frequencies of mothers mentioning for each category. The 205 mothers represent 205 children; seven mothers reported using more than one child care arrangement for one or more of their children.

Table B-7. Types of Preschool Child Care Arrangements FOR TARGET CHILD by Maternal Nativity[a]

Type of Care Provider	All Mothers (*N*=206)	Born in the US (*n*=113)	Foreign-born ≥ 5 years in US (*n*=65)	Foreign-born < 5 years in US (*n*=28)
Relative	30	33	29	18
Child care center/Head Start	33	32	40	18
School-based Pre-K	1	1	0	0
Friend/neighbor ***	19	7	26	52
Family child care***	12	20	2	0
Other (not specified)*	1	0	0	4

[a] Percentages are based on the frequencies of mothers mentioning for each category. The 206 mothers represent 206 children; seven mothers reported using more than one child care arrangement for one or more of their children.

APPENDIX C

Reported Service Providers Used at Year 3

Table C-1. Service Providers Reported by Mothers in Year 3 for Basic Needs[a]

Service Use Area	Frequency of Mention	Percent of Mothers Using Service Area[b]
Healthcare for mother or children (*n*=359)		
Medicaid	279	78
Private Insurance (e.g., Blue Cross, Blue Shield/BCBS; AETNA; CIGNA/SIGNA; CCN; Tricare; United Health Care)	34	9
Clinic (Department of Health; Lantana Clinic; St. Mary's Clinic; CARIDAD; PBC Health Care District; Beach Street)	21	6
KidCare (Florida KidCare)/Healthy Kids/ MediKids	13	4
Medical Doctor	11	3
Getting enough food (*n*=271)		
WIC	191	70
Department of Children and Families/Food Stamps	76	28
Medical Clinic/mental health center	3	1
Family planning or birth control (*n*=116)		
Lantana Clinic	41	35
Department of Health or Other Clinic	39	34
Medicaid	20	17
Private Insurance	5	4
Medical Doctor	4	3
Social service agency (Families First, Healthy Mothers/Healthy Babies)	2	2
Dental care (*n*=100)		
Clinic (e.g. Health Department (or Department of Health); CARIDAD; Clinic (Other); Health Care District; Beach Street)	14	14
Dentist	4	4
KidCare (Florida KidCare)/ MediKids	3	3
Medicaid	1	1
Private Insurance (e.g. Blue Cross, Blue Shield/BCBS; True Guardian Insurance; United Health Care)	6	6
Other	4	4
Child Care (*n*=90)		
Family Central	69	77
Head Start	9	10
YWCA	2	2
Other (e.g. Center for Family Services; Hispanic Humana School; Title 20; Children's Case Management Organization (CCMO); Human Resources; Department of Children and Families; Mary Alice Fortin Center; TANF/AFDC/Welfare; Workforce Alliance; Hugs for Kids; NOAH, Inc.)	11	12
Parenting information (*n*=45)		
Department of Children and Families	8	18
Healthy Mothers/Healthy Babies	4	9
Health Department (or Department of Heal	3	7
NOAH, Inc.	2	5
Hospital (Other)	2	5
Family Central	2	5
Hugs for Kids (Dick Webber)	2	5
First Care	2	5
Other (e.g. Early Childhood Partnership for Reading; Food Stamps; Hilltop Child Care Center; HRS; Medicaid; Medical Doctor; PBCC; Building Blocks; Parenting Education Center/CSC; ESEREH Youth and Family Center; Boys Town; Lantana Clinic; South County Mental Health Center, Inc.; St. Mary's Child Development Center; WIC; Head Start)	19	43

Table C-1 (cont.). Service Providers Reported by Mothers in Year 3 for Basic Needs[a]

Paying rent or bills (*n*=31)		
Community Action Program/Center (CAC)	8	27
Section 8/HUD	5	17
Human Services	2	7
Church/faith-based organization	2	7
Human Resources	2	7
Department of Children and Families	2	7
Other (e.g. Housing Authority; Lifeline Assistance; Adopt-a-Family; Board of County Commissioners; CCMO; Comprehensive Aids Program (CAP); Public Assistance; HRS; Department of Human Resources)	8	27
Housing (*n*=28)		
Section 8/HUD	12	43
Housing Authority (e.g., Palm Beach Housing Authority, PBC Housing Authority, South Bay Housing Authority, and Pahokee Housing Authority)	8	29
Other (e.g. Department of Children and Families; First Time Buyer Program - City of West; Food Stamps; CCMO; CAP; FEMA; NOAH, Inc.)	7	25
Transportation (*n*=25)		
Healthy Mothers/Healthy Babies	4	16
Workforce Alliance	2	8
Families First	2	8
Medicaid	2	8
Other (e.g. Building Blocks; Workforce Development; CCMO; Sickle Cell Foundation; NOAH, Inc.; Catholic Charities; Family Resources; Farmworker Coordinating Council; Hugs for Kids; Palm Tran; United Deliveries; Urban League; WIC; Healthy Start; Nurses; Hospital)	15	60
Legal issues (*n*=17)		
Legal Aid Society	8	47
Attorney/legal aid	8	47
Other (e.g. Center for Information & Crisis Services; Medicaid)	2	12
Employment (*n*=14)		
Workforce Alliance	6	43
Workforce Development	2	14
Other (e.g. David Wood Personnel; Ultimate Staffing; Youth Corps; Manpower; Personnel One; Unemployment)	6	43
Translating things into English (*n*=14)		
Health Department (or Department of Health)	3	21
School	3	21
Guatemalan-Maya Center Inc.	3	21
Healthy Mothers/Healthy Babies	2	14
Other (e.g. Legal Aid Society; AMO; I.R.S.)	3	21
Mental health or substance abuse (*n*=12)		
Alcoholics Anonymous	3	25
Medicaid	2	17
Other (e.g. Children's Case Management Organization; CAP; Counseling Services of Lake Worth; Institute for Family Living; Mind Renewal; South County Mental Health Center, Inc.; Healthy Solutions; DCF; Oakwood)	7	58
Buying clothes for your children (*n*=9)		
Adopt-a-Family	3	33
Other (e.g. Freecycle (online); Birth Line; ESEREH Youth and Family Center; Hugs for Kids; School; HRS; Red Cross)	6	67
Emergency shelter (*n*=5)		
Other (e.g. Harmony House; YWCA; Catholic Charities; FEMA; Red Cross)	5	100

Table C-2. Service Providers Reported by Mothers in Year 3 for Child Development Concerns[a]

Service Use Area	Frequency of Mention	Percent of Mothers Using Service Area[b]
Your child's physical health/illness (*n*=150)		
Clinic (e.g. Health Department (or Department of Health; Palm Beach County Health Care District; St. Mary's Clinic; Lantana Clinic; Clinic (Other))	6	4
Hospital (e.g. St. Mary's Hospital; Bethesda Hospital; Hospital (Other))	6	4
KidCare (Florida KidCare)/Healthy Kids/Children's Medical Services (CMS)	6	4
Medical doctor	15	10
Medicaid	106	71
Private insurance (e.g. CIGNA/SIGNA; Blue Cross, Blue Shield/BCBS; AETNA; CCN)	8	5
Social service agency (e.g. LAIRO; Early Steps)	3	2
Doing homework (*n*=29)		
School	12	41
After Care program	3	10
Boys & Girls Club	3	10
School Board	2	7
Other (e.g. Family Central; Beacon Center; Proud Friends; Solving Learning Center; Catapult; ESOL; After School; New Hope; Pahokee Pals; Glade Kids)	10	37
Your child's language and communication (*n*=26)		
School	5	19
ESOL	3	12
Medicaid	2	8
Early Head Start	2	8
Other (e.g. St. Mary's Hospital; Clinic (Other); Easter Seals Learning Center; Kids Medical Club - PSA Health Care; Lima Therapy Group; Child Find; Medical Doctor; Early Steps; Angel Children's Therapy; Kid Gluvs; Early Intervention Program (Part C); St. Mary's Child Development Center; Palm Beach County Health Care District; Pepe Head Start/Peppi; Children's Development Center)	15	58
Academic progress (*n*=21)		
School	12	57
ESOL	4	19
School Board	2	10
Other (e.g. Catapult; Alpha Best; Beacon Center; Glade Kids)	4	19
Your child's physical development (*n*=12)		
Medicaid	4	33
Other (e.g. St. Mary's Hospital; Medical Doctor; School; Early Steps; Easter Seals Learning Center; Children's Medical Services (CMS); Kids Medical Club - PSA Health Care)	8	67
Your child's problems paying attention (*n*=12)		
School	6	50
Other (e.g. St. Mary's Hospital; Alpha Best; Parent-Child Center, Inc.; Medical Doctor; Early Steps; Oakwood Center of the Palm Beaches; Department of Children and Families)	6	50
Your child's eating problems (*n*=8)		
Clinic	1	13
Hospital	0	0
Medicaid	2	25
Private Insurance	1	13
Other (e.g. Kids Medical Club - PSA Health Care; LAIRO; WIC)	3	38

Table C-2 (cont.). Service Providers Reported by Mothers in Year 3 by Service Area[a]

Your child's problems learning new things (*n*=6)		
School	3	50
Other (e.g. St. Mary's Hospital; Early Steps)	2	33
Your child's getting angry or upset (*n*=5)		
Other (e.g. Girls and Boys Town; Healthy Solutions; Oakwood Center of the Palm Beaches; Parent-Child Center, Inc.; Palm Beach County Health Care District; Multilingual)	5	100
Your child's getting along with peers…adults (*n*=4)		
Other (e.g. Medicaid; Oakwood Center of the Palm Beaches; School; Kiddie Haven)	4	100
Your child's withdrawal, sadness or depression (*n*=2)		
Other (e.g. Girls and Boys Town; Parent-Child Center, Inc.; Mental health center)	2	100
School attendance (*n*=2)		
School	2	86
Other (e.g. Glade Kids)	0	14
Your child's use of drugs/alcohol (*n*=1)		
Other (e.g. DATA)	1	100

[a] Data were weighted to adjust for the oversample of mothers from the Glades and mothers screened "at risk."
[b] Mothers could name more than one service provider for each service area and could mention the same service provider for more than one service area. Providers mentioned by only one respondent are not included.

APPENDIX D:

Child Maltreatment Rates in
Palm Beach County 2004-2006

Observed Child Maltreatment in Palm Beach County 2004-2006

The Florida Department of Children and Families (DCF) investigates all credible reports that a child has been the victim of physical abuse or neglect perpetrated by a person who is responsible for providing care to the child.. Most DCF investigations result in one of three formal findings, based on the level of proof that some harm occurred: the alleged maltreatment can be determined to be "verified," there can be a determination that "some indication" of abuse/neglect is present, or there can be a finding that there is "no indication" of abuse/neglect. These findings provide one indicator of the well-being of children within a community. Importantly, this information is available from the administrative records maintained by DCF.

To create a relatively simple measure of child maltreatment that can be used as an outcome variable for evaluation, the "verified" and "some indication" cases are here combined into a single category called "indicated" harms. All indicated cases involve at least some credible evidence that the child experienced a care situation involving maltreatment or that exposed the child to the risk of serious harm. It should be understood that these rates are indirect measures of maltreatment, as the events that are used to compute them are themselves the result of a potentially complex set of public and governmental behaviors. In order for an episode of abuse (or neglect) to contribute to these rates, someone must report it to the DCF hot line, it must be investigated by a protective worker, and the investigation has to determine that there is at least "some indication" that a harm has occurred. Each of these separate acts is potentially subject to variation by social conditions and by individual differences.

A potentially confounding problem in using maltreatment rates as an outcome measure for evaluating social service initiatives is that the involvement of health workers or other program personnel in the lives of these families can increase the likelihood that a harmful condition might be reported. For example, a home visitation program increases outsider contact with and scrutiny of the client families. Even if such a program provides supports and resources that effectively moderate the risks of harm to children, the short-term consequence may be an increased number of reports.

Maltreatment Rates for All Children 0 to 17 years

Using individual child-level records provided by DCF, annual child maltreatment incidence rates are tabulated for all of Palm Beach County, for the four targeted geographic areas (TGAs), and for the remaining non-TGA portions of the county. These rates are currently available for the years 2004, 2005, and 2006.[10] Rates are standardized measures because they adjust by comparing the number of events observed with the size of the population at risk of experiencing that event. In this report, maltreatment rates are computed for different geographic subareas of Palm Beach County, different years, and different age groups of child victims.

[10] DCF data were also provided for the first half of 2007. However, these records were produced in haste in the face of a major information system change at DCF, and they do not correspond well to the data from the earlier years. Therefore, 2007 results will be withheld until they can be verified by information to be produced by the new DCF information system.

Table D-1 presents child maltreatment rates per thousand by year and geographic area for all children ages 0-17 years. These are incidence rates, obtained by dividing the number of indicated victims (children with one or more indicated harms during the year) by the estimated child population (number of children at risk of harm), and multiplying the result by 1,000. The population estimates assume that growth has been constant and equal in all subareas of Palm Beach County from year 2000 through 2006.[11] As an example, the number 39.2 in the right upper cell in this table can be interpreted as follows: during the year 2006, 39.2 of every 1,000 children ages 0-17 in Palm Beach County were found by DCF to be indicated as victims of abuse/neglect. These rates can be compared across places, between subgroups, and across years because they are standardized by adjusting for the different populations at risk.

Examination of Table D-1 suggests that substantial differences can be observed in abuse/neglect rates between geographic places within Palm Beach County but that no noticeable and significant time trends appear during this short time period. Three of the four TGAs have consistently high maltreatment rates (for 2006, Riviera Beach is 51.8, West Palm Beach is 74.8, and Lake Worth/Lantana is 54.6), whereas the Glades TGA shows a much lower rate at 20.7 per thousand. Even so, the maltreatment rate for the Glades is noticeably higher than the 15.0 per thousand for the non-TGA remainder of Palm Beach County.

Figures D-1, D-2, and D-3 present these same rates by TGA and year in graph form, but now the rates are also classified for three separate age groupings of children. The first graph shows rates for the younger children (0-5 years of age), the second for children between 6 and 11 years, and the third for children and adolescents 12 to 17 years of age. Inspection of these graphs produces two main conclusions. First, age is clearly an important predictor of maltreatment levels. In every geographic area and for each year, maltreatment was highest for the younger children and lowest for the older children. Second, the basic pattern observed in Table D-1 is preserved within each age group. The three non-Glades TGAs have higher levels of indicated maltreatment, and the non-TGA remainder of Palm Beach County has lower rates of maltreatment. No changes over time were observed that showed consistent or significant patterns.

Maltreatment among Younger Children

It is apparent in Table D-1 and Figure D-1 that child abuse and neglect are more likely to be investigated and indicated for younger children in Palm Beach County. It would also be expected that if social programs targeting prenatal and early childhood issues would have an impact on child maltreatment that the effects would most likely occur among the younger children. For both of these reasons, and also to provide a comparison group that is more comparable to the longitudinal sample survey population, attention is shifted to maltreatment among children below the age of 2 years.

[11] The assumption of constant and equal growth is not really valid, but it does at least adjust for the fact that it is known that growth has occurred. Within a year or two, the new American Community Survey will allow for more accurate population estimates for small areas and smaller age groups (the TGAs are defined by zip code components).

Table D-1. Rates of Child Maltreatment for All Children Ages 0-17 in Palm Beach County and the TGAs 2004-2006

	Number of Children Indicated as Harmed (unduplicated within year)			Estimated Population at Risk			Rate of Harms (per 1,000 children)		
	2004	2005	2006	2004	2005	2006	2004	2005	2006
Palm Beach County									
0-5 years	3,156	3,257	3,395	83,149	84,901	86,652	38.0	38.4	39.2
6-11 years	2,326	2,437	2,230	92,366	94,311	96,257	25.2	25.8	23.2
12-17 years	1,758	1,793	1,706	87,065	88,899	90,733	20.2	20.2	18.8
Total	7,245	7,487	7,331	262,580	268,111	273,641	27.6	27.9	26.8
TGA-Riviera Beach									
0-5 years	363	348	339	3,796	3,876	3,956	95.6	89.8	85.7
6-11 years	237	190	190	4,640	4,738	4,835	51.1	40.1	39.3
12-17 years	139	165	148	4,116	4,202	4,289	33.8	39.3	34.5
Total	739	703	677	12,551	12,816	13,080	58.9	54.9	51.8
TGA-West Palm Beach									
0-5 years	828	858	924	7,822	7,987	8,151	105.9	107.4	113.4
6-11 years	519	640	509	7,929	8,096	8,263	65.5	79.1	61.6
12-17 years	428	395	385	7,558	7,717	7,876	56.6	51.2	48.9
Total	1,775	1,893	1,818	23,309	23,800	24,291	76.2	79.5	74.8
TGA-Lake Worth/Lantana									
0-5 years	450	486	449	5,345	5,458	5,571	84.2	89.0	80.6
6-11 years	273	293	242	5,031	5,137	5,243	54.3	57.0	46.2
12-17 years	165	206	168	4,723	4,822	4,922	34.9	42.7	34.1
Total	888	985	859	15,099	15,417	15,735	58.8	63.9	54.6
TGA-Glades									
0-5 years	132	115	164	4,165	4,253	4,340	31.7	27.0	37.8
6-11 years	81	93	74	4,708	4,807	4,906	17.2	19.3	15.1
12-17 years	69	69	50	4,507	4,602	4,697	15.3	15.0	10.6
Total	282	277	288	13,379	13,661	13,943	21.1	20.3	20.7
Four TGAs Combined									
0-5 years	1,773	1,807	1,876	21,128	21,573	22,018	83.9	83.8	85.2
6-11 years	1,110	1,216	1,015	22,307	22,777	23,247	49.8	53.4	43.7
12-17 years	801	835	751	20,903	21,343	21,784	38.3	39.1	34.5
Total	3,684	3,858	3,342	64,338	65,694	67,049	57.3	58.7	49.8
All Non-TGA areas									
0-5 years	1,138	1,167	1,259	62,021	63,328	64,634	18.3	18.4	19.5
6-11 years	1,050	1,024	1,012	70,058	71,534	73,010	15.0	14.3	13.9
12-17 years	826	822	834	66,162	67,556	68,949	12.5	12.2	12.1
Total	3,014	3,013	3,105	198,242	202,417	206,593	15.2	14.9	15.0

Figure D-1. Maltreatment Rates for Children Ages 0-5 Years[a]

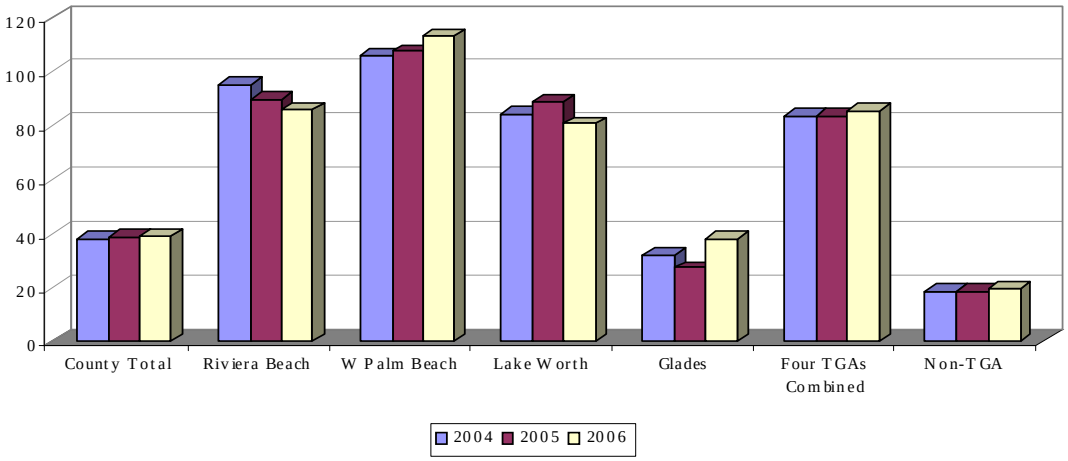


Figure D-2. Maltreatment Rates for Children Ages 6-11 Years[a]

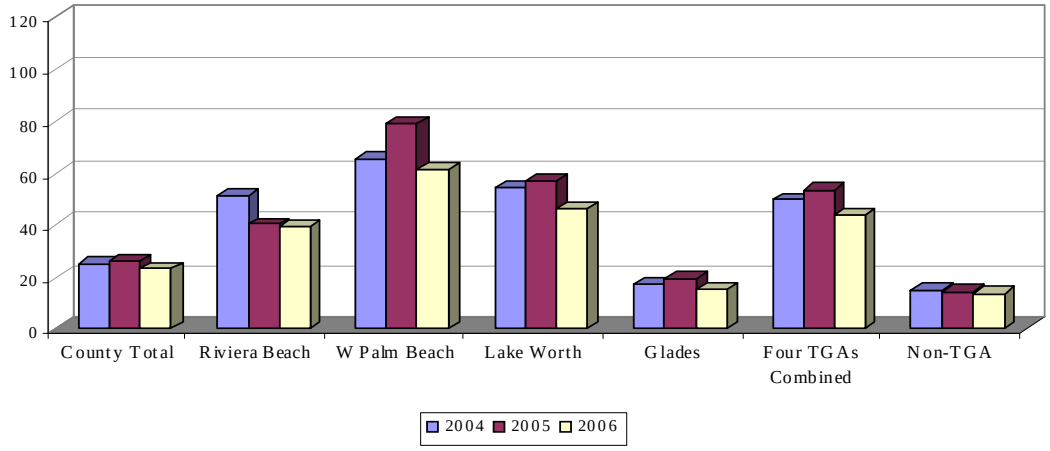
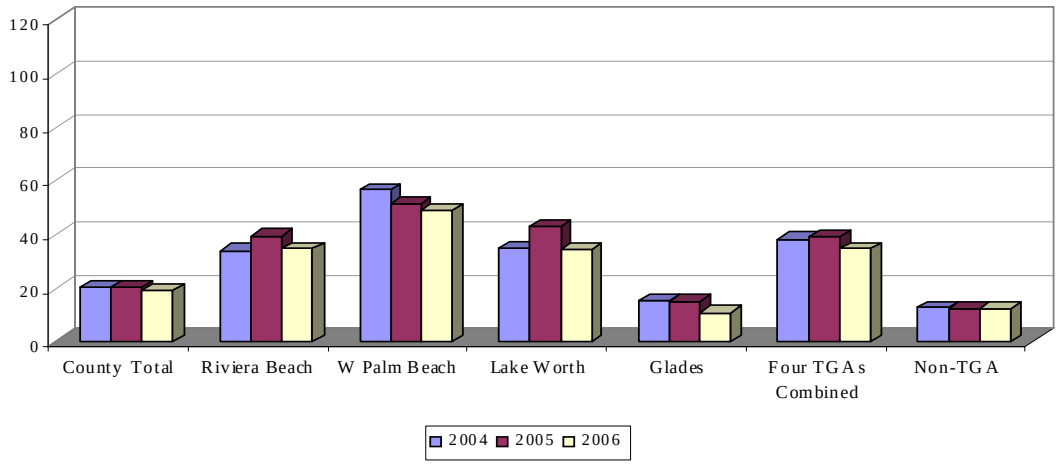


Figure 3-D. Maltreatment Rates for Children Ages 12-17 Years[a]



[a]Rates measured as the number of children (unduplicated) with indicated maltreatment during year, per 1,000 children.

During each annual period from 2004 to 2006, about 50 per thousand (5%) of all children under 2 years old in Palm Beach County were indicated by DCF as being victims of maltreatment . Table D-2 presents maltreatment counts and rates for children under 2, by year, geographic place, and age (0 or 1), and Figure D-4 shows these rates in graphical format. For every area and every year, the rates for children age 0 are higher than those for children age 1 year. As with the other child populations, the non-Glades TGAs have the highest rates, and the non-TGA areas the lowest rates[12]. The average annual maltreatment rates for children under 2 years are 47.9 per thousand for the Glades TGA, 72.3 for the other three TGAs combined, and 35.9 for the non-TGA portions of Palm Beach County.

Table D-2. Rates of Child Maltreatment for Children Ages 0-2 in Palm Beach County and the TGAs 2004-2006

	Number of Children Harmed			Estimated Population at Risk			Rate of Indicated Harms per 1,000 Children per Year			
	2004	2005	2006	2004	2005	2006	2004	2005	2006	Ave.
Palm Beach County										
0-1 years	738	767	813	13,293	13,573	13,853	55.5	56.5	58.7	56.9
1-2 year	546	550	591	13,541	13,826	14,111	40.3	39.8	41.9	40.7
Total 0-2	1,284	1,317	1,404	26,834	27,399	27,964	47.9	48.1	50.2	48.7
TGA-Glades										
0-1 years	39	30	47	702	717	732	55.5	41.8	64.2	53.9
1-2 year	32	19	23	593	605	618	54.0	31.4	37.2	40.7
Total 0-2	71	49	70	1,295	1,322	1,350	54.8	37.1	51.9	47.9
3 Non-Glades TGAs Combined										
0-1 years	385	431	427	4,853	4,955	5,057	79.3	87.0	84.4	83.6
1-2 year	279	274	297	4,597	4,694	4,791	60.7	58.4	62.0	60.4
Total 0-2	664	705	724	9,450	9,649	9,848	70.3	73.1	73.5	72.3
All 4 TGAs Combined										
0-1 years	424	461	474	5,555	5,672	5,789	76.3	81.3	81.9	79.8
1-2 year	311	293	320	5,190	5,299	5,409	59.9	55.3	59.2	58.1
Total 0-2	735	754	794	10,745	10,971	11,198	68.4	68.7	70.9	69.3
All Non-TGA areas										
0-1 years	314	306	339	7,738	7,901	8,064	40.6	38.7	42.0	40.4
1-2 year	235	257	271	8,351	8,527	8,702	28.1	30.1	31.1	29.8
Total 0-2	549	563	610	16,089	16,428	16,766	34.1	34.3	36.4	34.9

[12] From here forward, Riviera Beach, West Palm Beach, and Lake Worth/Lantana TGAs will be merged and treated as a single unit. This focuses the contrast of the differences between these three TGAs and the Glades. Because the longitudinal survey over-sampled the Glades TGA by design, merging the other three will facilitate comparison of DCF rate data with information from the survey.

Maltreatment for Longitudinal Study Participants

The DCF maltreatment records were also examined for the cases sampled in the longitudinal study.[13] Of the 390 children remaining in the longitudinal survey at the third year, 49 were observed to be victims of an indicated maltreatment, 12 children from the Glades and 37 children from the other three TGAs. Because of the timing of the survey, all of these children were ages 0 or 1 during the period of observation. The numbers from the longitudinal study can be converted to annual rates per 1,000 by defining the entire sample as the population at risk. Table D-3 compares the rates for sampled cases from the Glades TGA to the rates for sampled cases from the other three TGAs combined.

Table D-3. Observed Rates of Child Maltreatment Ages 0-2, Longitudinal Cohort Sample[a]

Sample	Number of Children Harmed	Estimated Population at Risk	Rate of Indicated Harms per 1,000 Children per Year
TGA-Glades			
0 years	8	94	85.1
1 year	6	94	63.8
Any (unduplicated)	12	188	63.8
3 Non-Glades TGAs Combined			
0 years	16	296	54.1
1 year	22	296	74.3
Any (unduplicated)	37	592	62.5
All DCF, Observed Annual Average			
TGA-Glades			
0 years	39	717	53.9
1 year	25	605	40.7
Any (unduplicated)	63	1,322	47.9
3 Non-Glades TGAs Combined			
0 years	414	4,955	83.6
1 year	283	4,694	60.4
Any (unduplicated)	698	9,649	72.3

[a] Maltreatment defined as a harm that is "verified" or where there are "some indicators" as determined by investigators. Unduplicated counts within year.

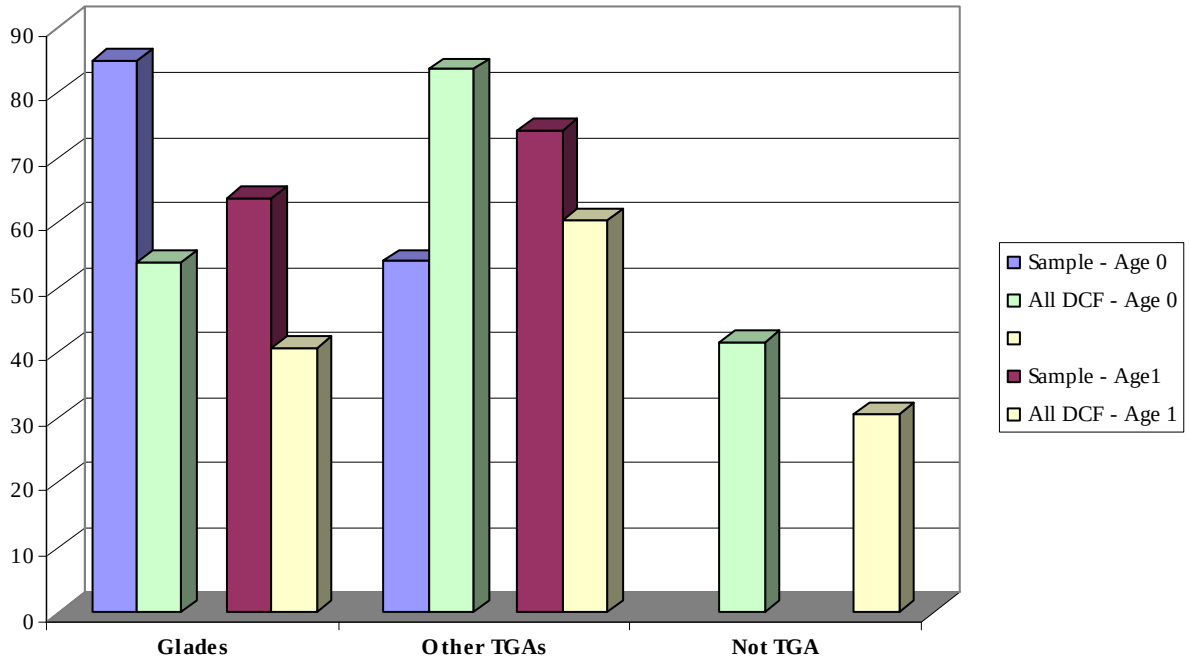
Although the rates for 1-year-old children from the sample resemble the familiar pattern of the Glades showing lower levels of child harm than the other three TGAs, this relation does not hold for the infants. For sampled infants, the Glades rate was 85.1 per thousand, whereas that for the other three TGAs was 54.1 per thousand. Because of the relatively small sample

[13] The longitudinal sample was linked to the DCF data by probabilistic record linkage techniques, using name and date of birth as the primary linkage criteria.

sizes, this difference is not statistically significant (p = .275),[14] but still is in marked contrast to what was observed in the larger population of all children ages 0 to 1, where the other three TGAs had a rate higher than the Glades by 72 to 48 per 1,000. For all children ages 0 and 1, the Glades sample exhibits total rates (64 per 1,000) that are just marginally higher than those in the sample from the other three TGAs (63 per 1,000). So, while the maltreatment rates for the longitudinal sample cases provide several unanticipated results, none of these is large or statistically significant.

In the lower section of Table D-3, the comparable rates from the entire DCF population are presented to allow comparison of the outcomes for the sample to those of the entire population. Table D-6 shows the rate comparisons as a graphic. Comparing the sample cases to the all DCF cases, it is clear that the biggest overall difference is for infants in the Glades TGA. Here the sample rate of 85.1 is almost significantly different for the observed DCF rate for all infants in the Glades (p = .085). This leaves the question as to whether the sample observation for infants in the Glades is an outlier, or whether some difference in the Glades sample leads to higher levels of abuse/neglect of infants.

Figure D-4. Comparison of Child Maltreatment between Longitudinal Sample Cases and All DCF Cases for Children Age 0 and Age 1 by Location[a]



[a] Rates are per 1,000 children. Non-TGA areas are not represented in the longitudinal sample.

[14] The Glades sample was 94 and the other three TGAs sample was 296. The significance level of p = .275 results from a comparison of two binomial proportions, .085 (8/94) for the Glades and .054 (16/296) for the other TGAs.

Types of Maltreatment

Table D-4 introduces a breakdown of child maltreatment by the type of harm perpetrated on the children. The first column ("Total") shows that substance-abuse-related harms and "threatened harm" were involved in well over one-half of all indicated harms on young children. The next three columns ("Calendar Year") suggest that neither the level of all harms nor that of any specific type of harm changed much during this time.[15] The next two columns ("Age of Child") provide new information. First, children are over one-third more likely to be victims during their first year of life than during their second year (62.6 per 1,000 compared with 46.2 per 1,000). Second, most of this difference is due to the much greater incidence of substance-related harms for children age 0 (20.7 per 1,000) than for children age1 (10.8 per 1,000).

The final three columns of Table D-4 ("Residence of Child") also provide some new insight into maltreatment among young children. In the four TGAs, the incidence rates for almost every type of harm were approximately double those observed in the non-TGA portions of the county. The single main deviation from this pattern is in the category of "threatened harm." Here, the non-TGA area had a rate of 16.6. whereas the Glades had a rate of 9.1 per thousand. The other three TGAs did have a higher rate at 37.0. Thus, the single unusual relation is that the Glades have a much lower rate of "threatened harm" cases than would have been expected from earlier findings.[16]

Table D-5 presents type of harm distributions for the 390 families in the year 3 study sample. Although the numbers are fairly small, the basic pattern is consistent with those observed in the full DCF data. In particular, substance abuse and threatened harm are the most frequent harms, and threatened harm is more than twice as frequent in the other three TGAs as it is in the Glades. Again, although the mechanism behind this relation is not well understood, the findings for the study families show consistency with the wider population from which they were drawn.

[15] There was a non-trivial increase in substance-abuse-related harms between 2005 and 2006. This may be the beginning of a trend and bears continued observation as newer data become available for 2007 and 2008.

[16] This under-representation of "threatened harm" in the Glades, as well as the area's lower overall harm rates, are not well understood. One theory is that the DCF staff in the Glades, which is a smaller community than the coastal TGAs, are much more familiar with the community and its families than DCF staff in other parts of the community. The Glades investigative unit operates as a single unit within a small service center that also houses economic self-sufficiency services. The DCF center is staffed by people who have lived and worked in the Glades for a long time. Thus, they are more likely to know the families and also can work more closely with the economic self-sufficiency staff to expedite the receipt of public assistance benefits and other services for their clients. This may also affect how the DCF determines if and when there is a real incidence of abuse and neglect.

Table D-4. Types of Maltreatment Found as Indicated by DCF Investigation for Children Ages 0-2 in Palm Beach County, 2004-2006

	Total 2004-2006	Calendar Year			Age of Child		Residence of Child		
							Glades	Other	Non-
Type of Harm	***N* Harms**	**2004**	**2005**	**2006**	**Age 0-1**	**Age 1-2**	**TGA**	**TGAs**	**TGA**
Threatened harm	1,926	637	633	656	1,024	902	36	1,071	819
Substance abuse	1,283	402	398	483	845	438	82	673	528
Physical injury	506	158	205	143	313	193	33	242	231
Lack of supervision	372	117	137	118	165	207	19	184	169
Environmental neglect	169	55	56	58	84	85	24	88	57
Special conditions	124	24	21	79	69	55	6	60	58
Lack of health care	46	19	17	10	28	18	5	19	22
Sexual maltreatment	20	9	6	5	11	9	0	8	12
Mental injury	10	5	1	4	4	6	0	3	7
Failure to protect	6	0	4	2	4	2	0	4	2
Death of other child	1	1	0	0	1	0	0	0	1
Death of child	1	0	0	1	1	0	0	1	0
All indicated harms	4,464	1,427	1,478	1,559	2,549	1,915	205	2,353	1,906
Annual prevalence rates per 1,000 children at risk									
Threatened harm	23.4	23.7	23.1	23.5	25.1	21.7	9.1	37.0	16.6
Substance abuse	15.6	15.0	14.5	17.3	20.8	10.6	20.7	23.2	10.7
Physical injury	6.2	5.9	7.5	5.1	7.7	4.7	8.3	8.4	4.7
Lack of supervision	4.5	4.4	5.0	4.2	4.1	5.0	4.8	6.4	3.4
Environmental neglect	2.1	2.0	2.0	2.1	2.1	2.0	6.0	3.0	1.2
Special conditions	1.5	0.9	0.8	2.8	1.7	1.3	1.5	2.1	1.2
Lack of health care	0.6	0.7	0.6	0.4	0.7	0.4	1.3	0.7	0.4
Sexual maltreatment	0.2	0.3	0.2	0.2	0.3	0.2	0.0	0.3	0.2
Mental injury	0.1	0.2	0.0	0.1	0.1	0.1	0.0	0.1	0.1
Failure to protect	0.1	0.0	0.1	0.1	0.1	0.0	0.0	0.1	0.0
Death of other child	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Death of child	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
All indicated harms	54.3	53.2	53.9	55.8	62.6	46.2	51.7	81.3	38.6

Table D-5. Types of Maltreatment Found as Indicated by DCF Investigation for Children Ages 0-2 in Year 3 Study Sample, 2004-2006

	Age of child at report				Residence of child at report			
	Age 0-1		Age 1-2		Glades		Other 3 TGAs	
Type of Harm	*n*	%	*n*	%	*n*	%	*n*	%
Physical injury	3	12.5	3	10.7	2	14.3	4	10.5
Substance abuse	6	25.0	5	17.9	4	28.6	7	18.4
Mental injury	0	0.0	0	0.0	0	0.0	0	0.0
Lack of supervision	3	12.5	4	14.3	3	21.4	4	10.5
Environmental neglect	3	12.5	1	3.6	1	7.1	3	7.9
Lack of health care	0	0.0	1	3.6	1	7.1	0	0.0
Threatened harm	9	37.5	11	39.3	3	21.4	17	44.7
Unknown or missing	0	0.0	3	10.7	0	0.0	3	7.9
All indicated harms	24	100.0	28	100.0	14	100.0	38	100.0

About Chapin Hall

Established in 1985, Chapin Hall is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities.

Chapin Hall's areas of research include child maltreatment prevention, child welfare systems and foster care, youth justice, schools and their connections with social services and community organizations, early childhood initiatives, community change initiatives, workforce development, out-of-school time initiatives, economic supports for families, and child well-being indicators.

1313 East 60th Street
Chicago, IL 60637

T: 773.256.5100
F: 773.753.5940

www.chapinhall.org

ChapinHall at the University of Chicago
Policy research that benefits children, families, and their communities